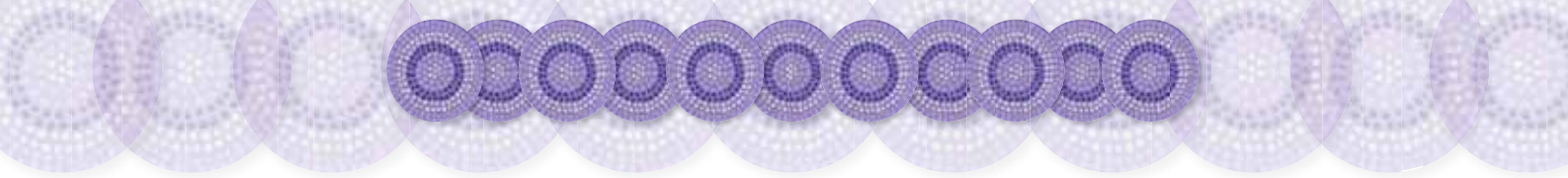


The Family Business

Improving the understanding
and treatment of
Post Traumatic Stress Disorder
among incarcerated
Aboriginal and Torres Strait Islander Women

Report





Acknowledgements

The research team would like to thank *beyondblue* for funding this work and enabling research specifically focused on the mental health of Aboriginal and Torres Strait Islander people.

The team would like to acknowledge the significant contribution of the 156 Aboriginal and Torres Strait Islander women at the Brisbane Women's Correctional Centre who participated in this research and we would like to thank them for their time and efforts. The participants had experienced numerous traumatic events yet were willing to expose and discuss these in an effort to positively influence outcomes for future generations of Aboriginal and Torres Strait Islander women who might share similar life experiences. We would also like to acknowledge those Murri women who volunteered to participate in a prisoner working group that provided advice and support to the research project.

The project team acknowledges the expertise and contribution from the expert reference group members: Dr Andrew Aboud, Dr Melissa Haswell-Elkins, Professor Ernest Hunter, Associate Professor Stuart Kinner, Associate Professor Katherine Mills, Coralie Ober, Angela Scotney and Megan Williams.

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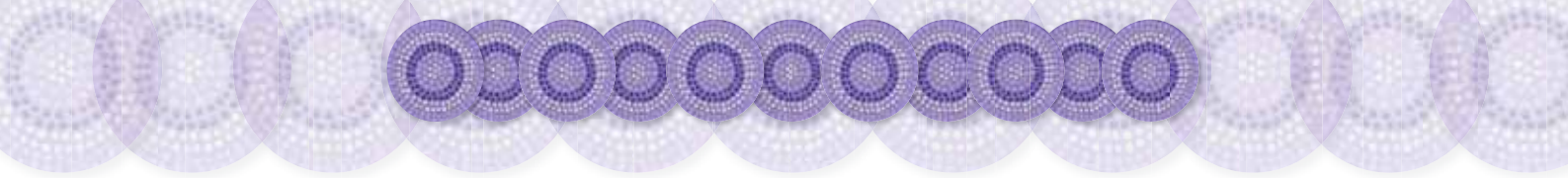
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Note on terminology: The authors of the report acknowledge the diversity that exists among Aboriginal cultures in Australia, and the language and cultural practices of different Torres Strait Islander people. This report uses the term 'Indigenous' to describe Aboriginal and Torres Strait Islander People; this is in part because reference articles and government departments apply this term more regularly.



Cultural Context

The influence of both Aboriginal and Torres Strait Islander cultures on the method, design and data analysis of this study was significant. This report demonstrates that culturally competent research practice is achievable in a challenging research environment, and therefore achievable outside of this environment. In doing so it draws attention to the challenges faced by Indigenous women in custody and highlights the need for service providers to build upon their cultural capabilities to positively influence outcomes for these women.

Communities of Indigenous women in custody possess very distinct characteristics; these include a collective experience of intergenerational trauma, shared with other Indigenous Australians. This study highlighted trauma experiences common among this population. The participants in this research were represented by a working group of women in custody. Among other significant contributions, this group had responsibility for naming the project.

The title of this report **Family Business** acknowledges how the family unit holds a great deal of significance for Indigenous peoples and is an integral element in sustaining culture and practices. In naming this report the participants of the working group wanted to ensure that the significance of family to Indigenous culture was recognised. In discussing family one of the women from the working group said *“I am the last member of my (immediate) family to enter the family business (come to jail)”*. The group discussed this and determined that “the family business” was a meaningful name because *“...not only do generations of our families have to deal with the impact of imprisonment, but it is through our families the healing will take place”*.

The research team acknowledges that for Aboriginal and Torres Strait Islander community members the data presented in this report may be confronting to review. Through consultation with participants, the reference group, community members and stakeholders, including a community consultation forum (see Appendix 1) Aboriginal and Torres Strait Islander members supported the need to investigate and examine this complex topic. This subject matter is considered a health priority for Indigenous Australians. The presentation of these findings will assist to engage mental health and other services to consider approaches that meaningfully address this challenge.

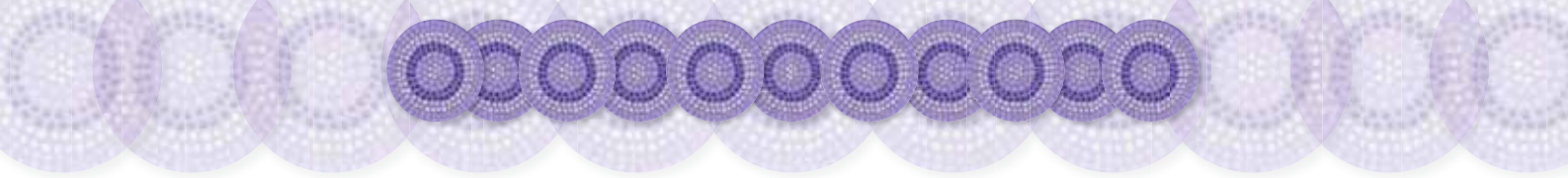
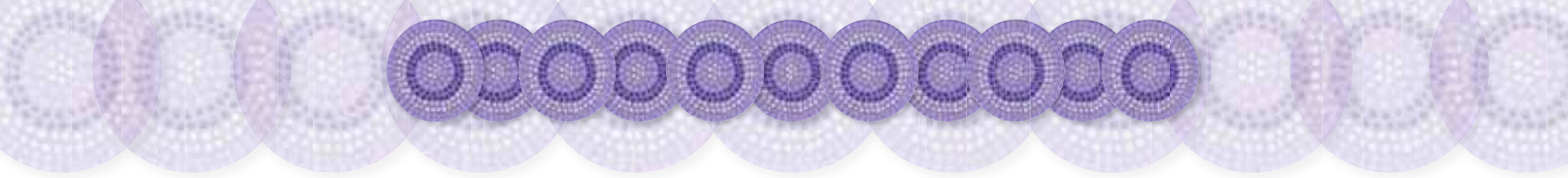


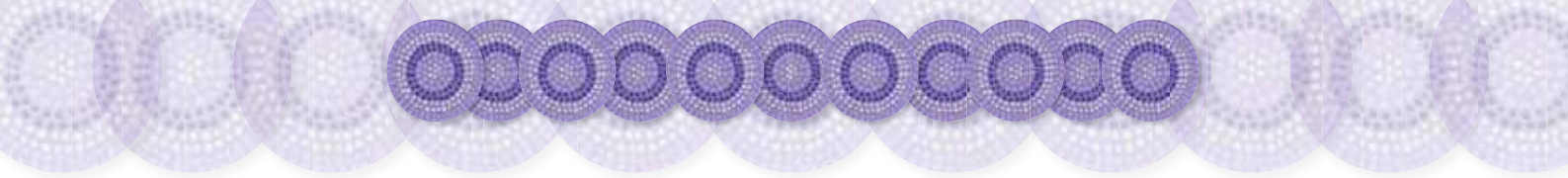
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Key Messages

- Aboriginal and Torres Strait Islander women are 20 times more likely than non-Indigenous women to be incarcerated, and the majority of those who are incarcerated suffer from mental disorder. This is a serious and poorly understood public health problem.
- The most common mental disorder in incarcerated Aboriginal and Torres Strait Islander women is Post-Traumatic Stress Disorder (PTSD). Almost half of the women we assessed in custody had this condition.
- PTSD in these women often had its onset in adolescence, was debilitating and chronic, and was complicated by the presence of other mental disorders such as depression, psychosis and alcohol and cannabis dependence.
- PTSD is often misdiagnosed or not diagnosed, particularly among Indigenous women for whom the presentation of the condition is influenced by unique cultural, historical and social factors. Very few Indigenous women in custody with PTSD have received any treatment for the condition.
- Central to the development of PTSD for many of these women are experiences of the traumatic and unexpected death of a loved one, sexual assault (for many occurring prior to the age of 10) and being the victim of serious violence.
- There are clear links between the extremely high rates of mental disorder in this group, limited access to appropriate mental health care in community and custody, and the vast over-representation of Indigenous women in custody.
- It is critical that culturally capable mental health care is made available to Indigenous women in custody and as they transition back to the community.



Executive Summary

Background

Post-Traumatic Stress Disorder (PTSD) is a serious and often chronic mental health condition that affects around one in every 15 Australians each year. PTSD is more common in women and is the most common mental disorder in prisoners. Indigenous women are over-represented in adult prisons by a factor of 20. The aim of this research was to determine how common PTSD is and how it impacts on incarcerated Indigenous women and to make recommendations for identification and treatment of PTSD in custodial settings. This research assessed 116 incarcerated Indigenous women in Queensland using scientifically rigorous and culturally capable methods.

Mental Health Findings

It is estimated that almost half (47%) of Indigenous women in custody suffer from PTSD, and that a large proportion suffer from other mental disorders including other anxiety disorders (70%), depressive disorders (39%) and psychotic disorders (17%). It is estimated that almost two thirds of Indigenous women in custody (63%) have a substance use disorder. The prevalence of these disorders is orders of magnitude higher among incarcerated Indigenous women, than among women in the general community.

Results indicate that incarcerated Indigenous women with PTSD were more likely to have other mental disorders, particularly depressive disorders, psychotic disorders and substance use disorders. More than one third (38%) of women with PTSD had a cannabis use disorder, compared with 16% of those without PTSD. Women with PTSD were also much more likely to report experiencing high or very high levels of psychological distress in prison. These findings indicate that among an already profoundly disadvantaged group, those suffering from PTSD have particularly significant and complex mental health needs.

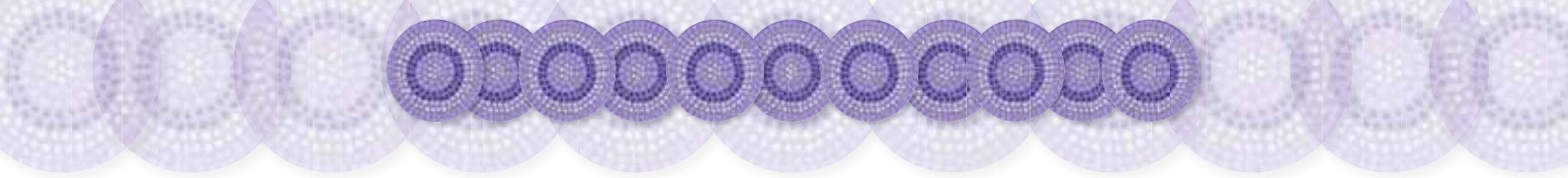
Trauma

All of the women diagnosed with PTSD in this study had experienced multiple traumatic events – on average five distinct traumas over the course of their life. Among the most common traumatic events was the sudden death of a loved one, being the victim of serious domestic violence or sexual assault, and observing serious physical violence in the home as a child. Women with PTSD were much more likely than those without PTSD to have experienced sexual assault and many reported experiencing this trauma before the age of 10. Most of the women with PTSD had been suffering this condition for most of their adolescent and adult life.

Participants also reported a number of traumatic experiences particularly relevant to Indigenous Australians. Among those with PTSD, more than one in four identified as a member of the stolen generation, half reported being removed from their family as a child, 43% reported having their own children removed and more than three quarters had been the victim of racism or discrimination. Women with PTSD were more likely than those without PTSD to report not feeling accepted by their family or community. For Indigenous Australians, both the causes and the presentation of PTSD are likely to be influenced by historical and social factors impacting on individuals and the community.

Suicide

Among the 116 Indigenous women we assessed, 30% had thought about suicide and 22% reported having attempted suicide at some point in their life. A similar proportion (21%) reported having engaged in deliberate self harm. Both deliberate self harm and suicide attempts were considerably more common among those women who suffered from PTSD, and are orders of magnitude higher among Indigenous women in custody than among women in the general community. Treatment responses and support services for these women must take into account their markedly elevated risk of self-harm and suicide, both in custody and after return to the community.



Culture

Qualitative interviews and a specific culturally validated measure of Growth and Empowerment identified positive cultural experiences and beliefs, and a strong commitment to community among Indigenous women with PTSD. While individuals with PTSD scored lower on the majority of measures of growth and empowerment when compared with those without PTSD they scored at similar levels with respect to empowerment through their own spirituality and participation in their community. The identification of strengths is important to informing treatment approaches. The women with PTSD also identified that participation in group activities with other Murri women, such as “yarning circles” as likely to make a positive contribution to holistic treatment for PTSD. In addition having Indigenous service providers involved in their health care was viewed as extremely positive, as was the ability to participate in elder visits and activities that enhanced connection to their community.

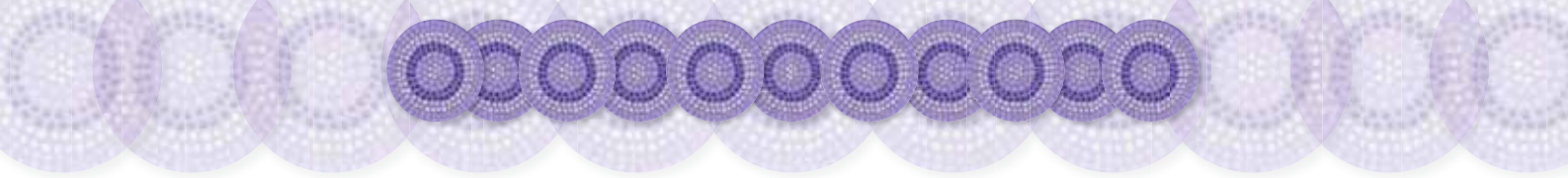
Transition to the community

Despite their significant mental health needs, almost half (43%) of women with PTSD reported no contact with mental health services in the community before coming into prison, and around a quarter (27%) did not intend to access any form of mental health care after return to the community. Of those who had accessed care, only a third (35%) were satisfied with the care they had received. There is a clear need to both improve access to mental health care for Indigenous women who experience incarceration, and to ensure that this care is both effective and culturally appropriate. Given that many of these women cycle in and out of prison on multiple occasions, continuity of care between prison and community is critical to effective mental health care.

Recommendations

This is the most comprehensive study of PTSD in incarcerated Indigenous women ever undertaken. While further research is required to fully understand and evaluate identification and treatment of PTSD in this population, based on the findings of this research we recommend the following:

1. That correctional services and other departments and agencies in contact with this population adopt a trauma-informed approach to care.
2. That assessment for PTSD, using reliable, valid and culturally sensitive tools, should become part of routine health screening practices for Indigenous people in custody.
3. That mental health care delivery is adaptable to the constraints and uncertainties of custodial settings in determining an appropriate treatment response for PTSD.
4. That narrative therapy is trialed as the primary treatment approach for PTSD in incarcerated Indigenous women.
5. That a range of therapeutic programs for PTSD and related problems be made available in custody and post-release, and be delivered in a manner that is flexible and responsive to the individual’s evolving needs.
6. That mental health assessment in custodial settings involves Indigenous health staff, and that all staff in correctional settings be culturally competent.
7. That consumers of mental health services in prison be linked to community treatment and support services, prior to release, in a manner that maximises continuity of care.
8. That further research be undertaken to evaluate the effectiveness of culturally sensitive PTSD Interventions for Indigenous women in custody.



1. Context

What is Post-Traumatic Stress Disorder?

Post-Traumatic Stress Disorder (PTSD) is a mental health condition that is triggered by a terrifying event, either experienced or witnessed. It may occur as a result of a one-off event such as a car accident, or repeated events such as childhood sexual abuse. The sufferer has four types of problems: (a) re-living the traumatic experience, (b) feeling ‘wound up’, (c) avoiding reminders of the event, and (d) negative thoughts and feelings (1). The impact of PTSD varies between individuals however in the more severe forms it can be chronic and pervasive, affecting all major life domains. People with PTSD are more likely to experience poor physical and mental health and are at higher risk of suicide than the general population (2, 3). Examples of day-to-day difficulties include feeling anxious and struggling emotionally, having trouble sleeping or concentrating, interpersonal and relationship difficulties, as well as poor self-esteem, difficulties trusting others and problems with functioning in the workplace.

How common is PTSD?

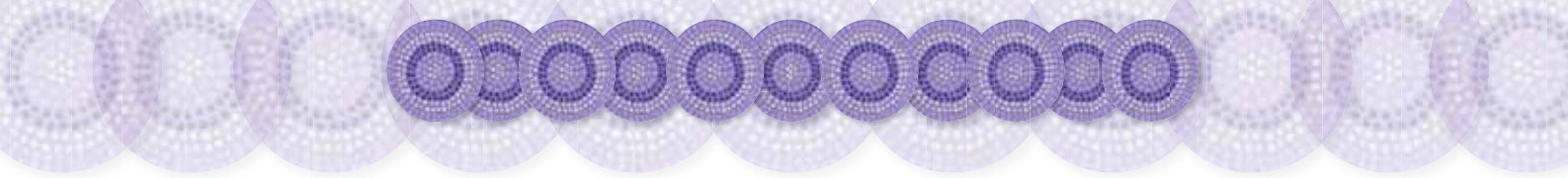
The most recent national survey of mental health and well-being estimated that 6.7% of people in the Australian community had experienced PTSD in the preceding 12 months (4) however this survey excludes people in custody. Individuals in the Australian community with PTSD report that the condition has a significant impact on social and work functioning, and is associated with other mental health problems, particularly substance misuse. There are no reliable national estimates of the prevalence of PTSD in Indigenous Australians, who experience a much higher burden of disease than non-Indigenous Australians (5, 6) and report higher levels of psychological distress (7). It is likely that the prevalence of PTSD is higher in the Indigenous population than in non-Indigenous Australians. Given that the prevalence of PTSD is much higher in custodial populations (8) and amongst women in general (4), it is likely that Indigenous women in custody represent a particularly vulnerable group with respect to PTSD.

Background and Research Questions

Aboriginal and Torres Strait Islander people have shorter life expectancy, higher infant mortality rates, higher levels of psychological distress and a greater disease burden than non-Indigenous Australians (6, 9, 10). While these health challenges have received national recognition and commitment to action through the Close the Gap campaign (11), less well recognised is the insidious growth in the rate of incarceration of Indigenous Australians (12). The gap between Indigenous and non-Indigenous incarceration rates has widened over the past two decades and at present, Indigenous men are fifteen times more likely and Indigenous women twenty times more likely to be incarcerated than their non-Indigenous counterparts.

In 1991, following the release of the report of the Royal Commission into Aboriginal Deaths in Custody (13), the over-representation of Indigenous people in custody became prominent in the public conscience. A central theme of the report was that Indigenous Australians should be incarcerated as a sanction of last resort. Another key theme was the prominence of mental disorder as a driver of poor outcomes for Indigenous people: “The ninety-nine cases have highlighted the issue of mental health as a significant underlying issue and a factor of concern for those who died in custody” (23.3.3)(13). Despite this, almost two decades passed before reliable data outlining the nature and extent of mental disorder among Indigenous people in custody became available (14, 15). These recent, landmark studies documented for the first time how widespread mental health problems were among Indigenous Australians in prison.

From these studies it became apparent that PTSD was the most common mental disorder suffered by Indigenous people in custody. This was no surprise to those who understood the trauma experienced by Indigenous people through the colonisation of lands, the forced removal of children and exposure to other traumatic experiences of violence, loss, discrimination and childhood abuse (5, 16, 17). However, the pervasiveness of this disorder among women was of particular concern, with estimates suggesting that between one third to a half of all Indigenous women in custody suffer from PTSD (14, 15).



Recent research has also shown that after release from custody, Indigenous people experience particularly poor health and social outcomes, high rates of hospitalisation for mental health problems, substance-related problems and injury, and a markedly increased risk of death, most often due to substance-related causes, suicide or preventable injury (18-22). The poor health of prisoners, particularly incarcerated Indigenous women, is clearly a significant public health issue.

In the context of this, it is pertinent to ask: *How do we identify Indigenous women in custody suffering PTSD, and how do we provide them with appropriate mental health care?*

In considering this question it is critical to consider mental health challenges from an Indigenous social and emotional well-being perspective (5), and therefore how PTSD among Indigenous Australians will be influenced by their unique cultural, spiritual, health-related and historical experiences (23). The evidence on this topic is extremely limited (1). In this study we attempt to address these questions by firstly exploring, through quantitative and qualitative research methods, the nature, extent, triggers and symptom profile of PTSD among Indigenous women in custody. In the second half of the report we consider how to identify those suffering from PTSD, and how best to provide mental health care for these women.

2. Approach

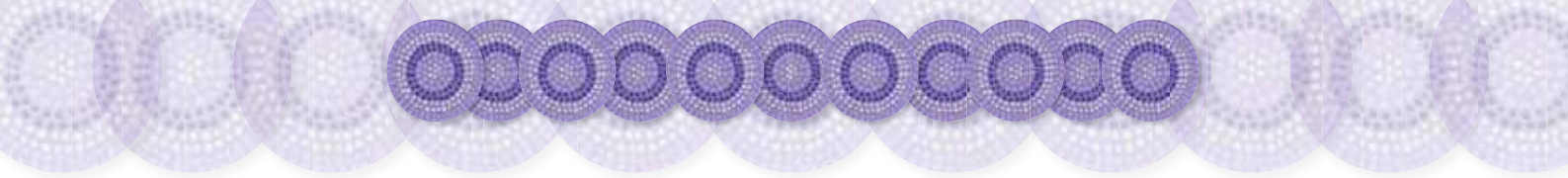
Study Design and Participants

The Family Business study was cross-sectional in design and included three components: (1) screening for PTSD, (2) a structured interview and diagnostic assessment, and (3) a qualitative interview. Participants were women who identified as Aboriginal, Torres Strait Islander or both, were aged 18 years or over and were held (either sentenced or on remand) in Queensland's largest women's custodial centre (Brisbane Women's Correctional Centre) at some point during the recruitment period. Interviews took place over a 10-month period from 29 July 2013 to 20 May 2014. All participants provided informed, written consent. Ethical clearance for the study was obtained from the local health service ethics committee and from the Queensland Corrective Services (QCS) Research Committee.

The research process relied upon leadership from Aboriginal and Torres Strait Islander researchers, academics and other stakeholders to inform the design, implementation, analysis and interpretation of the results. This included a community consultation process and ongoing communication with a prisoner working group within the correctional centre.

All consenting individuals were screened for the presence of PTSD using the 7-item Breslau Short Screen for PTSD (24). Those who screened positive and every second woman who screened negative was invited to participate in a structured interview and diagnostic assessment. In addition, a subset of women who screened positive for PTSD also took part in a qualitative interview.

Data were collected by face-to-face interview with Indigenous research staff, in confidential interview rooms. PTSD screening and the structured interview were administered in paper and pencil format (see Appendix 2). The diagnostic assessment involved administering the Composite International Diagnostic Interview (CIDI) on a laptop computer. Qualitative interviews were audio recorded, with consent, on a digital voice recorder. The structured interviews and diagnostic assessment took between 30 and 120 minutes to complete, depending on the complexity of the issues that were identified. Qualitative interviews took between 10 and 40 minutes to complete. Interviewers were supervised by a senior Indigenous clinician (Investigator Andersen) and additional clinical support was provided by a forensic psychiatrist (Investigator Heffernan). There were clear guidelines to support both routine and emergency clinical needs.



Procedures and Measures

The interview and assessment process included three components:

1. Paper-based, structured questionnaire
2. Clinical diagnostic interview
3. Qualitative interview

1. Questionnaire

The questionnaire included questions about demographics, custodial experiences, mental health service experiences and suicide thoughts and actions. In addition, there was a psychosis screening tool (25) and a variety of PTSD-related measures including:

- Trauma Symptom Checklist (TSC 40) (26)
- Post-Traumatic Cognitions Inventory (PTCI) (27)
- Kessler Psychological Distress Scale (K5) (28)
- Growth and Empowerment Measure (selected items) (29)
- Culturally-specific trauma events questions, developed by the research team

2. Clinical Diagnostic Interviews

The World Health Organization World Mental Health – Composite International Diagnostic Interview (CIDI) Computer Assisted Personal Interview version 21.1.3 (30) was used to assess participants for the presence of anxiety, mood and substance disorders. For women who screened positive for psychosis, psychotic disorders were established by psychiatrist interview, with clinical information recorded on a proforma and reviewed by a panel comprised of two forensic psychiatrists and a cultural advisor (an Indigenous mental health clinician) in order to reach a consensus diagnosis and minimise the risk of cultural bias (31).

3. Qualitative Interviews

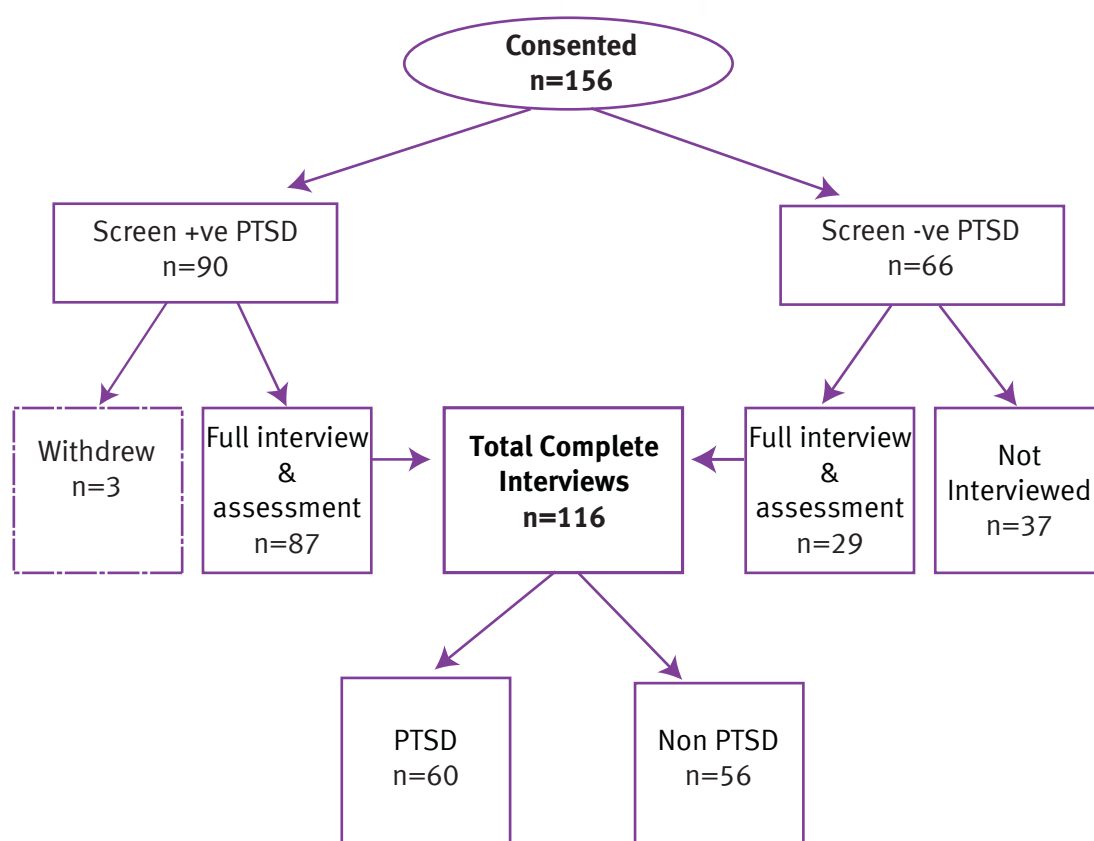
Qualitative interviews were conducted with a subset of the women who screened positive for PTSD, to enable them to share their views about the nature and impact of PTSD on their life, and provide advice about treatment approaches they perceived as useful. These interviews occurred either immediately after the structured interview and assessment, or in a subsequent session.

3. Results

Who were the participants?

During the recruitment period 233 women were identified as eligible to participate in the study. Of these, 48 were discharged prior to providing consent or participation, 25 declined to participate and 4 were judged as unable to participate leaving 156 women who consented (67% of all eligible women). Of these, 90 (58%) screened positive for PTSD and 66 (42%) screened negative. One hundred and sixteen women completed the structured interview and assessment, and 38 of these also completed a qualitative interview (Figure 1). Throughout this report, this group of 116 women is referred to as the participants in the study. Among these 116 participants, 60 (52%) were diagnosed with PTSD and 56 (48%) were not (see ‘Prevalence of PTSD’, below, for more information).

FIGURE 1. PTSD screening and interview process



In this report we focus on the 116 participants who took part in the interview and assessment. Where relevant, we have compared findings for those with and without a diagnosis of PTSD, and attempted to put the findings into context by providing comparison with findings from the Australian National Survey of Mental Health and Well Being (4). While we acknowledge the limitations with this direct comparison (due to lack of standardisation for age or Indigenous status), the stark differences in prevalence estimates help to contextualise the findings.

Because of our approach to recruitment (interviewing all women who screened positive for PTSD and every second woman who screened negative), we intentionally over-sampled women likely to have PTSD. As such, where we consider the prevalence of PTSD and other mental health conditions, we report both the observed prevalence in our sample of participants (N=116) and the estimated prevalence in the wider group of women who were screened for PTSD (N=156). The estimated prevalence is more likely to be a true reflection of the prevalence of these conditions among incarcerated Indigenous women in general.

Table 1 outlines the demographic characteristics of participants. The mean age was 31 years and 58% reported being in a stable relationship. Most (85%) identified as Aboriginal. The vast majority (92%) reported receiving Centrelink benefits prior to incarceration and 41% had less than 10 years of education. There were no significant differences in demographic characteristics between those with and without a diagnosis of PTSD (all $p > 0.05$).

Table 1. Demographic characteristics of participants with and without PTSD

	PTSD (n=60) n (%)	Non PTSD (n=56) n (%)	Full sample (N=116) n (%)
Indigenous status			
Aboriginal	51 (85)	47 (84)	98 (85)
Torres Strait Islander	0 (0)	2 (4)	2 (2)
Aboriginal & Torres Strait Islander	7 (12)	6 (11)	13 (11)
Aboriginal & South Sea Islander	2 (3)	1 (2)	3 (3)
Age (mean years)	29.8	31.6	30.7
Relationship status			
In a relationship	34 (57)	33 (59)	67 (58)
Education completed			
< Year 10	26 (43)	22 (39)	48 (41)
Income ^a			
Centrelink	53 (88)	54 (96)	107 (92)
Paid employment	3 (5)	3 (5)	6 (5)
Crime or other	7 (12)	0 (0)	7 (6)
Parent of child/children	41 (68)	43 (77)	84 (72)
Children in care of others ^a			
Government	14 (23)	12 (21)	26 (22)
Kinship	23 (38)	27 (48)	50 (43)
Friend	0 (0)	1 (2)	1 (<1)
Other	2 (3)	7 (13)	7 (13)

^a more than one option may apply

All participants were incarcerated in the Brisbane Women's Correctional Centre. They had all been charged with a criminal offence (see Appendix 3 for details) and were either remanded in custody or serving a sentence related to these charges. A review of their life experiences of custody (Table 2) identified that while there were no significant differences between the PTSD and non PTSD groups in terms of adult custodial experiences, those with PTSD had almost twice the odds of having spent time in youth custody (Odds Ratio (OR)=1.9, 95% Confidence Interval (CI) 0.8-4.3, p=0.08).

Table 2. Lifetime custodial experiences of participants with and without PTSD

	PTSD (n=60) n (%)	Non PTSD (n=56) n (%)	Full sample (N=116) n (%)
Current custodial status			
Sentenced	37 (62)	25 (45)	62 (53)
Remanded	21 (35)	30 (54)	51 (44)
Not known	2 (3)	1 (2)	3 (3)
Youth detention ever	27 (45)	17 (30)	44 (38)
Number of adult incarcerations ever			
Mean	4.3	4.5	4.4
Total time in adult custody ever			
Mean (months)	29.8	23.8	26.9

Mental Health

Prevalence of PTSD

Of the 87 women who screened positive for PTSD and participated in the interview and assessment, 51 were diagnosed with PTSD, suggesting that 59% of those who screen positive using the screening instrument will suffer from PTSD. Of the 29 participants who screened negative for PTSD but participated in the interview and assessment, 9 were diagnosed with PTSD, suggesting that 31% of those who screen negative will suffer from PTSD. Given the number of women who were misclassified according to the screening tool, these findings raise doubts about the utility of the screening tool used for the detection of PTSD among incarcerated Indigenous women.

Among those who completed the interview and assessment (N=116), 60 (52%) were diagnosed with PTSD and 56 (49%) were not. Among those diagnosed, the mean age of onset was 15.7 years (range 4–47 years). Applying these percentages to all women who were screened (N=156), we estimate that the 12 month prevalence of PTSD in this group was 47%, and thus that nearly half of the Indigenous women we screened had the diagnosis of PTSD in the past 12 months. Given the mean age of the sample (30.7 years) and mean age of onset (15.7 years), most had experienced PTSD for the majority of their adolescent and adult life.

To put these findings into context, in Figure 2 we compare our prevalence estimate from this study to the 12 month prevalence of PTSD among non-incarcerated Australian females in general. The estimated prevalence of PTSD in incarcerated Indigenous women (47%) was more than five times higher than the estimated prevalence among women in the general population (8.3%).

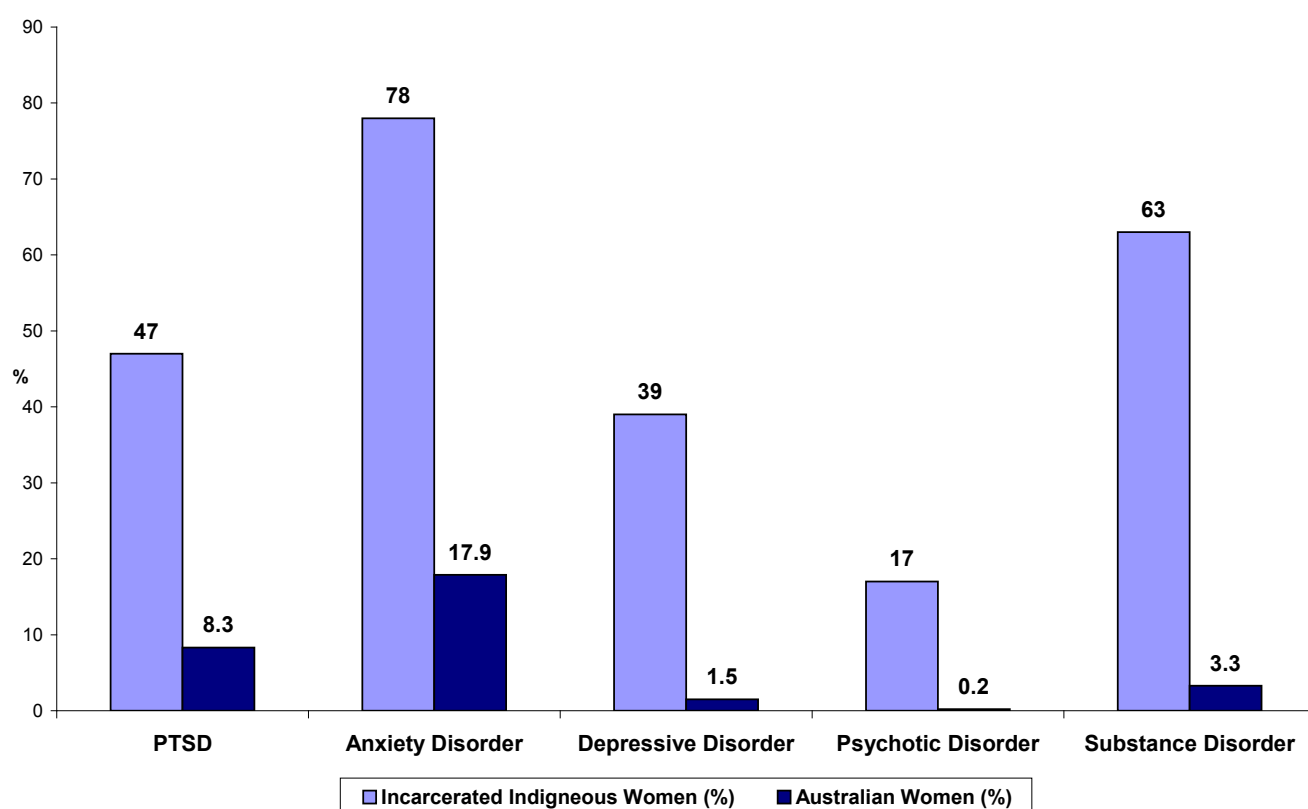
Prevalence of other mental disorders

The 12 month prevalence of mental disorder observed in the 116 women who completed the interview and assessment was 81% for anxiety disorders, 26% for depressive disorders, 27% for psychotic disorders¹ and 68% for substance use disorders. Therefore, among those who were initially screened for PTSD (N=156) we obtained the following 12-month prevalence estimates: anxiety disorders, 78%; depressive disorder, 39%; psychotic disorders, 17% and substance use disorders, 63%.

¹ The prevalence of psychosis is likely to be underestimated. A small number of women who screened positive were unable to be interviewed by a psychiatrist to confirm diagnosis (due to release or transfer). As such, these women have not been included in the group of women who were given the diagnosis of psychosis.

Figure 2 presents a comparison of these prevalence estimates with estimates for non-incarcerated women in the Australian community (4, 32). The prevalence of all mental disorders was orders of magnitude higher among incarcerated Indigenous women than among non-incarcerated Australian women.

Figure 2. Estimated 12-month prevalence of PTSD and other mental disorders in incarcerated Indigenous women and non-incarcerated women in Australia



Note: Prevalence estimates for non-incarcerated women in Australia obtained from Slade et al (2009) and Morgan et al (2011). Anxiety disorder category includes PTSD.

Co-occurring mental disorders

We compared the prevalence of anxiety (other than PTSD), depressive, psychotic and substance use disorders between participants with and without PTSD. Compared to women without PTSD, women with PTSD had five times the odds of having a co-occurring depressive disorder and almost three times the odds of having a co-occurring substance use disorder. Those with PTSD were also more likely to be diagnosed with another anxiety disorder and with a psychotic disorder, although these differences were not statistically significant ($p > 0.05$). Overall, compared with women who did not have PTSD, women with PTSD had about four times the odds of having another mental disorder.

Table 3. Mental disorder in participants with and without PTSD

ICD-10 12 month diagnoses	PTSD (n=60) n (%)	Non PTSD (n=56) n (%)	Full sample (N=116) n (%)	OR (95% CI)
PTSD	60 (100)	0 (0)	60 (52)	n.a.
Anxiety (excl. PTSD)	44 (73)	37 (66)	81 (70)	1.4 (0.6 – 3.4) p = 0.26
Depression	24 (40)	6 (10)	30 (26)	5.6 (1.9 - 18.1) p < 0.001
Psychosis	16 (26)	8 (14)	24 (21)	2.2 (0.8 – 6.5) p = 0.08
Substance use	47 (78)	32 (57)	79 (68)	2.7 (1.1 - 6.7) p = 0.02
Any co-occurring disorder	57 (95)	46 (82)	103 (89)	4.1 (0.97-24.4) p = 0.03

Substance use disorders

Substance use disorders were extremely common in our sample (N=116): 35% suffered an alcohol use disorder and 53% a drug use disorder. We compared the prevalence of specific substance use disorders between women with and without PTSD (Table 4). Those with PTSD had three times the odds of having a cannabis use disorder and more than twice the odds of having an alcohol use disorder, although the latter difference did not quite reach statistical significance. Those with PTSD were also more likely to have amphetamine and other drug disorders, although these differences were not statistically significant ($p > 0.05$)

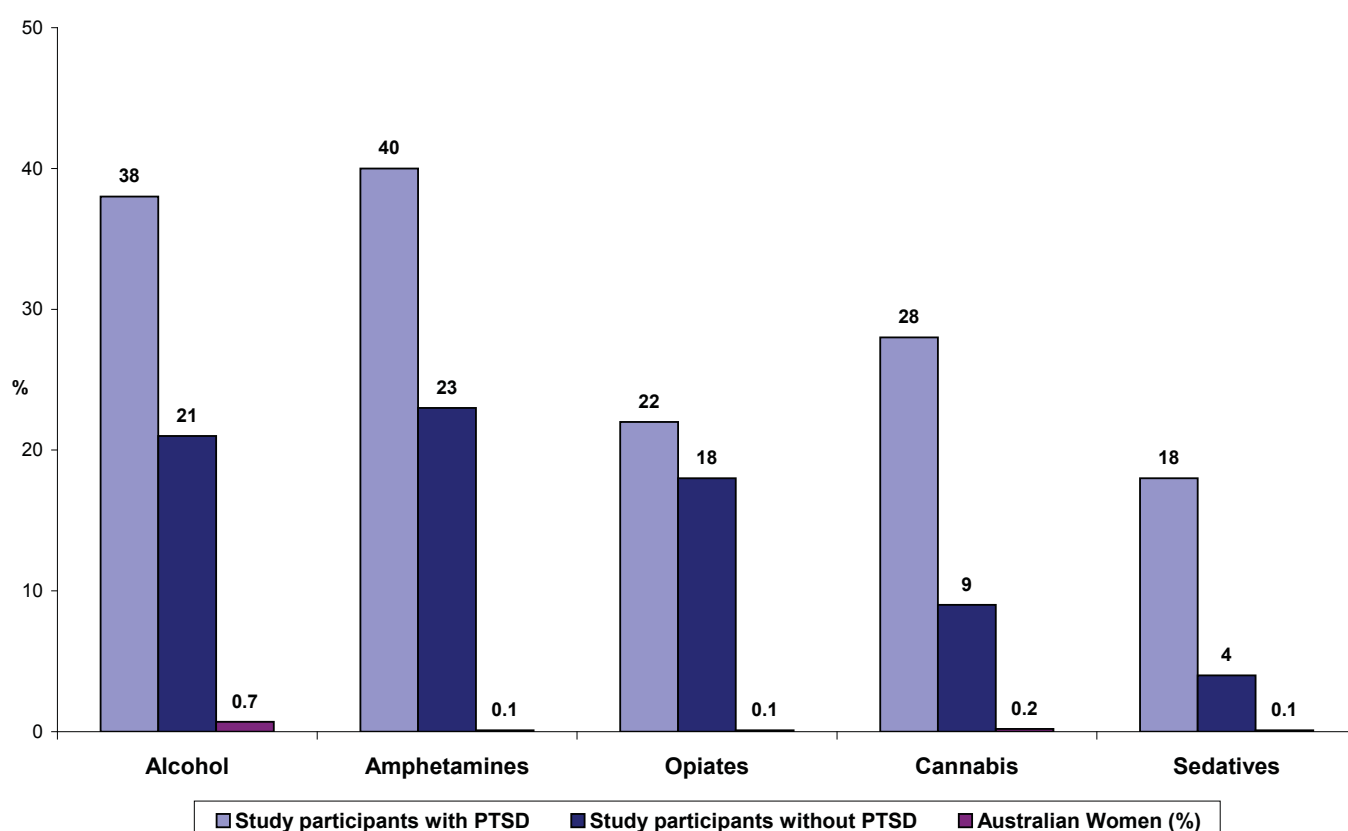
Table 4. Substance use disorder in participants with and without PTSD

ICD-10 12 month diagnoses	PTSD (n=60) n (%)	Non PTSD (n=56) n (%)	Full sample (N=116) n (%)	OR (95% CI)
Alcohol	27 (45)	16 (29)	43 (37)	2.1 (0.9 - 4.8)
Harmful use	4 (7)	4 (7)	8 (7)	p = 0.07
Dependence	23 (38)	12 (21)	35 (30)	
Amphetamines	29 (48)	20 (36)	49 (42)	1.7 (0.8 - 3.8)
Harmful use	5 (8)	7 (13)	12 (10)	p = 0.12
Dependence	24 (40)	13 (23)	37 (32)	
Opiates	15 (25)	14 (25)	29 (25)	1.0 (0.4 – 2.5)
Harmful use	2 (3)	4 (7)	6 (5)	p = 0.58
Dependence	13 (22)	10 (18)	23 (20)	
Cannabis	23 (38)	9 (16)	32 (28)	3.3 (1.3 – 8.9)
Harmful use	6 (10)	4 (7)	10 (9)	p = 0.006
Dependence	17 (28)	5 (9)	22 (19)	
Sedatives	13 (22)	4 (7)	17 (15)	1.3 (0.5 – 3.6)
Harmful use	2 (3)	2 (4)	4 (3)	= 0.61
Dependence	11 (18)	2 (4)	13 (11)	
Other drugs*	16 (27)	10 (18)	26 (22)	1.7 (0.6 – 4.6)
Harmful use	9 (15)	6 (11)	15 (13)	p = 0.18
Dependence	12 (20)	4 (7)	16 (14)	

(*hallucinogens, ecstasy, pain killers, inhalants, cocaine, other substances)

To assist in contextualising the extent of substance dependence (the most severe form of substance use problems) amongst incarcerated Indigenous women we compared the 12 month prevalence of dependence on a variety of substances between participants with PTSD, participants without PTSD and non-incarcerated women in the Australian community (4) (Figure 3). For all evaluated substances, the estimated prevalence of substance dependence was higher in those with than those without PTSD, and orders of magnitude higher in participants than among women in the general community.

Figure 3. 12-month prevalence of substance dependence in study participants with and without PTSD, and in non-incarcerated women in Australia



Note: Prevalence estimates for non-incarcerated women in Australia obtained from Slade et al (2009).

Psychological distress

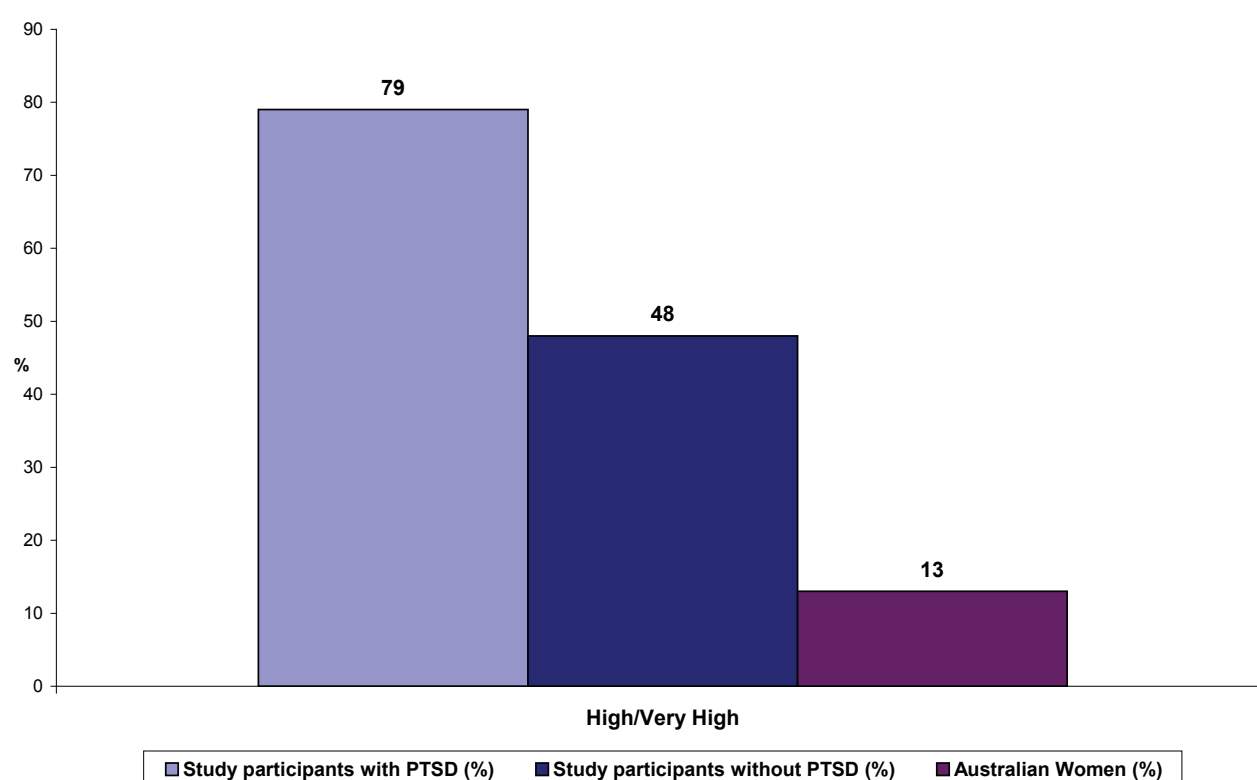
We assessed participants for current psychological distress using the K5 (33). Compared with women who did not have PTSD, those with PTSD had about four times the odds of reporting high or very high levels of psychological distress (OR=4.1, 95%CI 1.7-10.4, $p < 0.001$) (Table 5). In Figure 4 we compare the estimated prevalence of high/very high psychological distress among participants with and without PTSD, and women in the general community (34).

Table 5. Prevalence of psychological distress in participants with and without PTSD

Kessler 5 score category	PTSD (n=58 ^a) n (%)	Non PTSD (n=54 ^a) n (%)	Full sample (N=112 ^a) n (%)
Low/Moderate Distress	12 (21)	28 (52)	40 (35)
High/Very High Distress	46 (79)	26 (48)	72 (62)

^a K5 score missing for 2 participants in each group

Figure 4. Prevalence of high/very high psychological distress in study participants with and without PTSD, and in non-incarcerated women in Australia



Note: Prevalence estimates for non-incarcerated women in Australia obtained from ABS (2012).

Suicide thoughts and actions

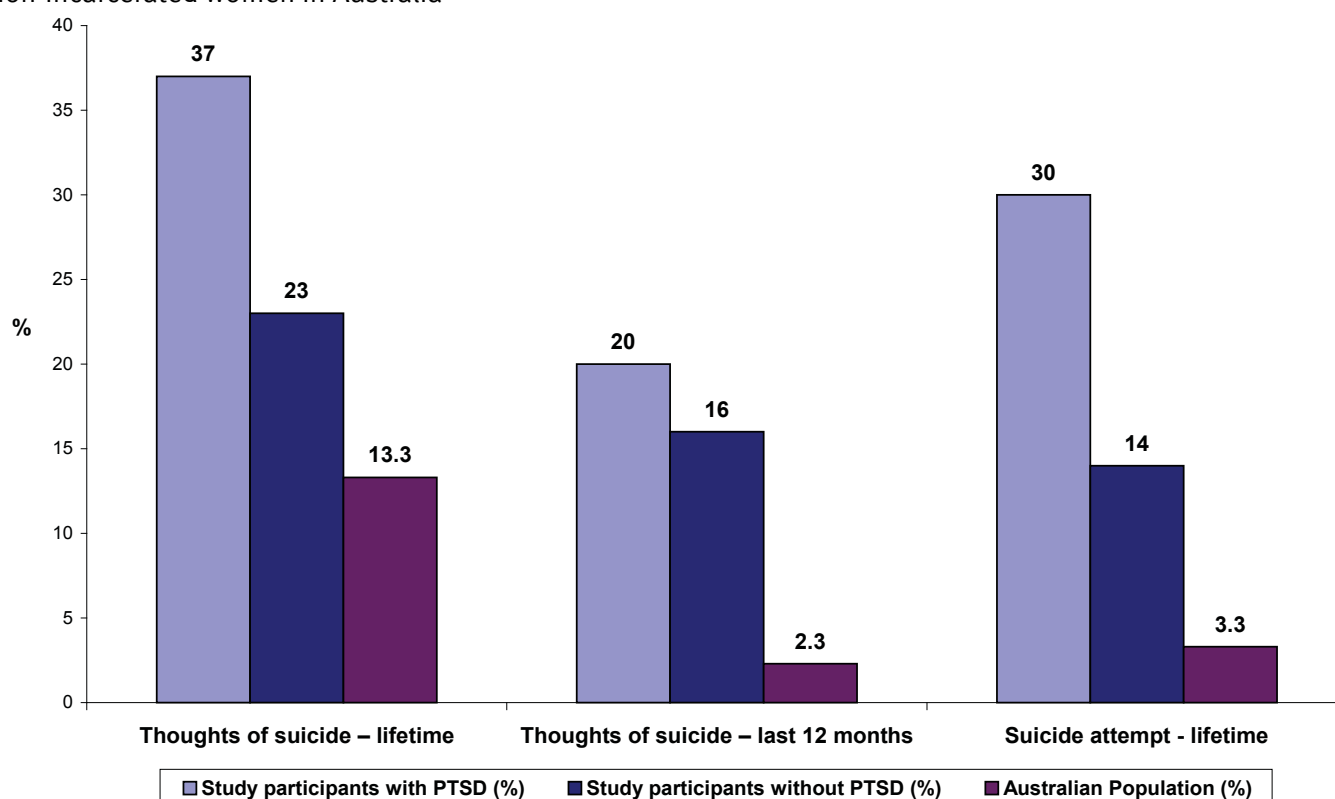
Table 7 shows the proportion of participants with and without PTSD reporting suicidal thoughts, deliberate self-harm and a history of suicide attempts. Those with PTSD had more than twice the odds of reporting lifetime suicidal thoughts and lifetime suicide attempts; and almost three times the odds of reporting deliberate self-harm.

Table 7. Prevalence of suicidal thoughts and actions in participants with and without PTSD

	PTSD (n=60) n (%)	Non PTSD (n=56) n (%)	Full sample (N=116) n (%)	OR (95% CI) p =
Thoughts of suicide – lifetime	22 (37)	13 (23)	35 (30)	2.1 (0.9 – 5.3) p = 0.051
Thoughts of suicide – last 12 months	12 (20)	9 (16)	21 (18)	1.3 (0.5 – 3.9) p = 0.38
Suicide attempt - lifetime	18 (30)	8 (14)	26 (22)	2.6 (0.9 – 7.5) p = 0.04
Deliberate self harm – lifetime	17 (28)	7 (13)	24 (21)	2.8 (0.97 – 8.6) p = 0.03

To provide some context for these findings, in Figure 5 we compare the prevalence of suicidal thoughts and behaviour among participants with and without PTSD, and women in the Australian community. The prevalence of suicidal thoughts and behaviour was higher among those with than those without PTSD and markedly higher among participants than among women in the general community (4).

Figure 5. Prevalence of suicidal thoughts and behaviour in study participants with and without PTSD, and in non-incarcerated women in Australia



Note: Prevalence estimates for non-incarcerated women in Australia obtained from Slade et al (2009).

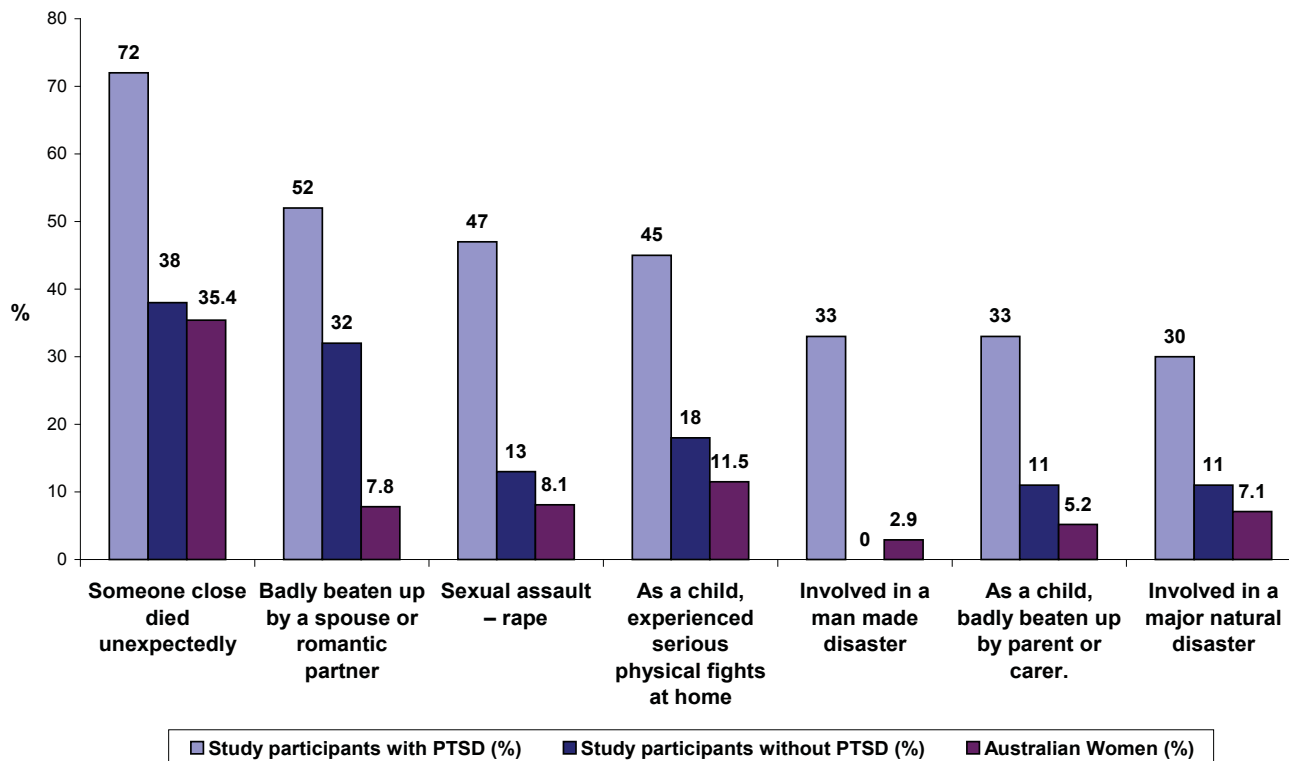
Trauma Specific Measures

In addition to assessing participants for PTSD and other mental disorders, we used a range of measures to examine more closely the types of trauma and PTSD symptoms experienced by participants.

Trauma events

Participants with PTSD reported experiencing at least two and as many as 45 traumatic experiences in their lifetime (see Appendix 4 - lifetime trauma events table). The mean age at which participants reported experiencing their worst trauma was 16.4 years. While Appendix 4 outlines all trauma experiences, in Figure 6 we show the estimated prevalence of the most commonly reported traumatic experiences among participants with and without PTSD, and compare this with non-incarcerated women in the Australian community (35). The prevalence of traumatic experiences was (as expected) higher among participants with than without PTSD and markedly higher among participants than among non-incarcerated women in the general community. Among the most commonly reported traumatic experiences among participants were the sudden death of a loved one, being the victim of serious domestic violence or sexual assault, and observing serious physical violence in the home as a child.

Figure 6. Prevalence of selected trauma events in study participants with and without PTSD, and in non-incarcerated women in Australia



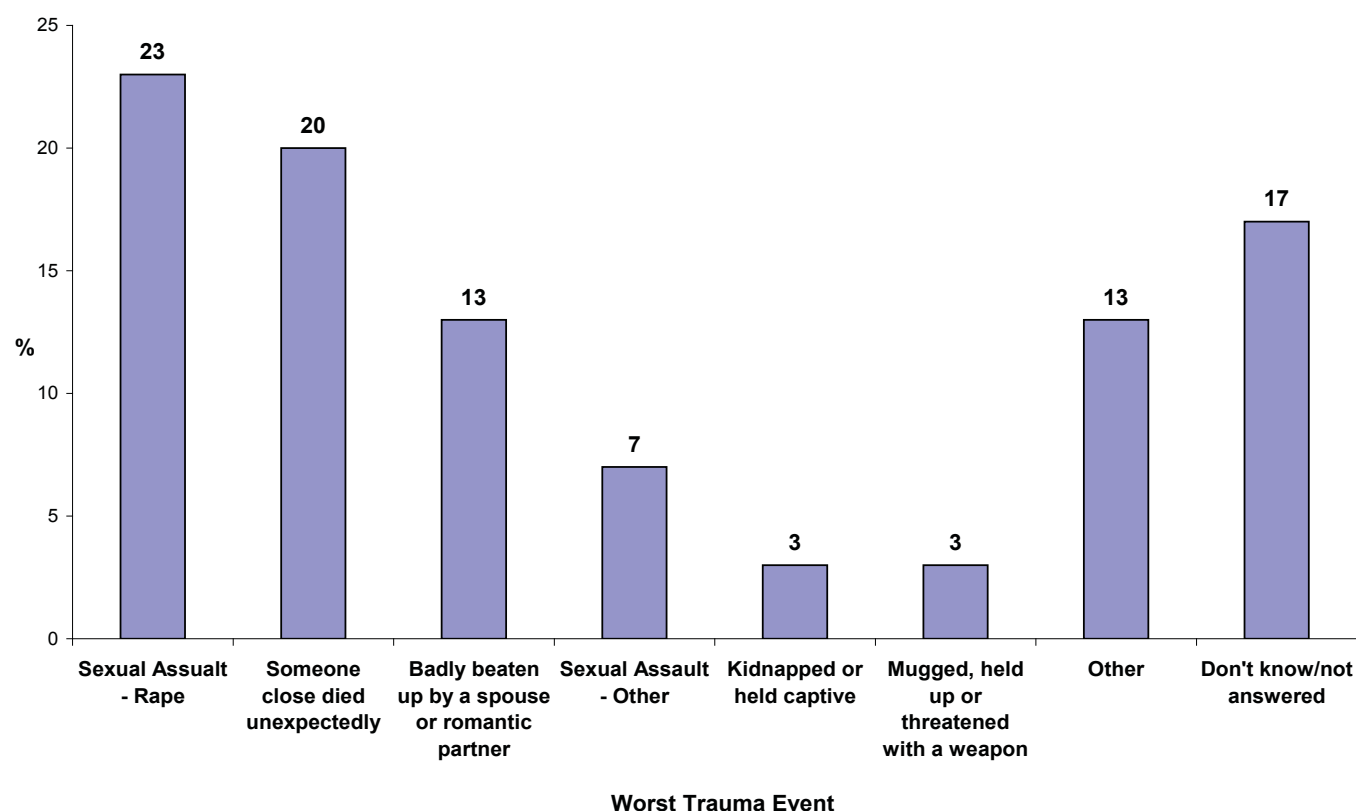
Note: Prevalence estimates for non-incarcerated women in Australia obtained from Mills et al (2006).

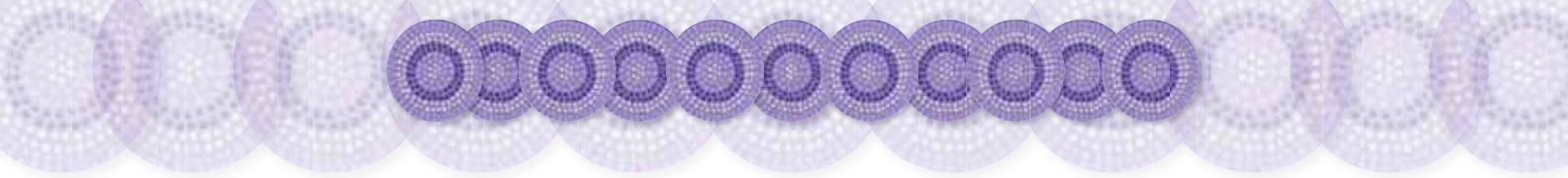
In addition to the trauma experiences that are part of the standard questionnaire for the general population, we asked our participants about some additional potentially traumatic experiences reflecting the unique history and experience of Indigenous Australians (Appendix 5). Many participants with PTSD identified as a member of the stolen generation (28%), reported being removed from their family as a child (50%), had their own children removed (43%) or were a victim of racism or discrimination (77%). These experiences were not unique to participants with PTSD but shared across the cohort of Indigenous women in custody, irrespective of a diagnosis of PTSD. However, women with PTSD were significantly more likely than those without PTSD to report not feeling accepted by their family (OR=3.23, 95% CI 1.3-8.1, p=.003) or their own community (OR=1.99, 95%CI 0.9-4.5, p=.049).

Worst Trauma Experiences

Participants with PTSD were asked to identify the trauma experience that they considered to have been their “worst” trauma experience; that is, the experience that caused them the most problems, or most severe problems, that were identified as contributing to their symptoms of PTSD (Figure 7). The impact of being a victim of sexual assault, the unexpected death of a loved one and being a victim of violence were clearly prominent trauma experiences. The findings with respect to sexual assault highlighted just how prevalent this traumatic experience is amongst Indigenous women in custody (see Appendix 6). We found that those with PTSD were nearly five times more likely than those without PTSD to have been a victim of sexual assault or rape; the mean age of experiencing these traumas was 9.3 years and 10.2 years respectively.

Figure 7. Worst trauma event experienced by women with PTSD





Trauma impact

A variety of measures was used to examine the various functional impacts of PTSD on individuals with the condition (Appendix 7). Individuals with PTSD reported symptoms associated with higher levels of dissociation, anxiety, depression, sexual abuse trauma and sexual problems than individuals without PTSD. Individuals with PTSD also reported higher rates of negative cognitions (Appendix 8) and self-blame. They were also administered the Growth and Empowerment Measure (29), an instrument designed to assess an individual's subjective sense of empowerment, strengths, problem solving abilities and coping skills (Appendix 9) – and those individuals with PTSD scored lower on the majority of measures compared with those without PTSD, although both groups were comparable on the measures of spirituality and community connection.

Health Service Utilisation

Participants with PTSD were also asked to describe their experiences of contact with health services prior to incarceration. Almost half (43%) reported no contact with mental health services (including specialist mental health services, general practitioners, community health centres, psychologists, counsellors or cultural healers) prior to incarceration. Of those who did have mental health care contact (see Appendix 10) a wide variety of mental health care providers had been accessed, but only a third (35%) of those who had accessed mental health care reported that they were satisfied with the care they had received.

When asked about intended access to mental health care services post release, around a quarter (27%) of the women with PTSD did not intend to access health care services in the community (Appendix 11). Of those who did intend to access mental health care after release from custody, the most frequently identified service provider was a GP (30%).

Transitional Support

Accommodation was the most pressing issue that women needed to be addressed on release. Some women were not able to return to close family because of Child Protection orders. Secure accommodation was seen as being a foundation for starting again and keeping out of trouble. Other than accommodation, other services requested were continuity with the kind of services they might receive in jail, such as access to mental health services, support or rehabilitation services for drug and alcohol problems, emotional support, and importantly, access to further support programs related to life skills relevant to community living.

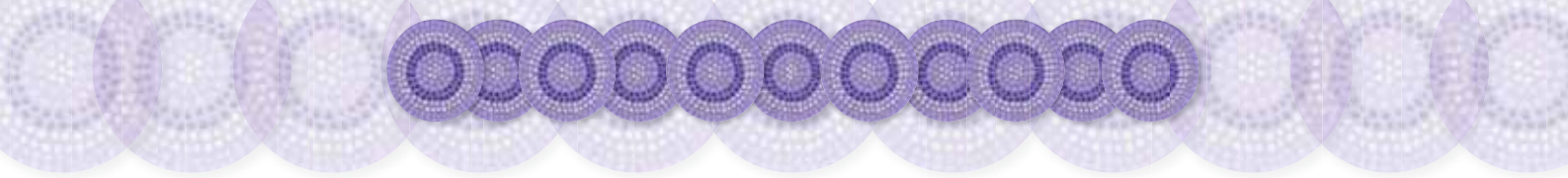
Qualitative Results

Thirty eight women who screened positive for PTSD were asked to participate in an interview about their experiences of PTSD and health services, either directly after the diagnostic interview or at a later date. During these interviews they were asked questions related to the impact of PTSD on their lives and the types of services they thought would be useful to support them in custody and in transition to the community. The transcripts from the 38 interviews were analysed using NVIVO 10 (36) to identify relationships and themes within the data. Key themes identified from the analyses are outlined below.

Impact of PTSD

Key symptom experiences commonly identified included difficulty sleeping and nightmares, depression and paranoia, emotional numbing and high levels of anxiety.

“So I was hoping if I could get some help of doing any type of courses that will help me to stay clean and be there for my children because my anxieties are coming up and I’m a mess. My paranoia is kicking in. Everything is kicking in and I don’t know why.”



Many women described a lack of confidence arising from their experience of PTSD symptoms and identified this impacting on their ability to access employment, an association with involvement in crime, and fear of people in authority such as police and correctional officers.

“...she was a nice (parole) lady but she was saying to mum, get me to ring up so that we can book her another appointment and I won’t have to breach her, but I started getting paranoid thinking that if I went there they’d have the police in the room waiting for me.”

Participants also described how having parents who were members of the stolen generation had impacted them.

“Dad still cries in his sleep and stuff...We thought that was the way to go like, in our household, growing up. To this day now we all grown up we still see it...cause every one of my siblings are either a woman basher, domestic violence, drug addict, or alcohol or criminal, and you know it’s sad because we know our little brother is gonna go that way, cause we seen our dad do it. Like the Mexican wave it just goes like that.”

Health Care Experiences

Half of those interviewed reported that they had asked for help with their experiences of PTSD. Of those who obtained help, only a small number found it useful. Most participants identified having an Indigenous person involved in their care as important. The majority of participants identified drug and alcohol problems and mental health care as key areas in which they needed help. In fact, a number of participants identified custody as a safe place as it offered help in these two areas. Other areas in which participants felt that they required assistance included housing, support networks, reconnecting with family, dealing with domestic violence and transitioning out of custody.

A number of women talked about the importance of services being offered by Indigenous staff. They did not feel comfortable talking to non-Indigenous people and did not think that non-Indigenous people could understand their problems.

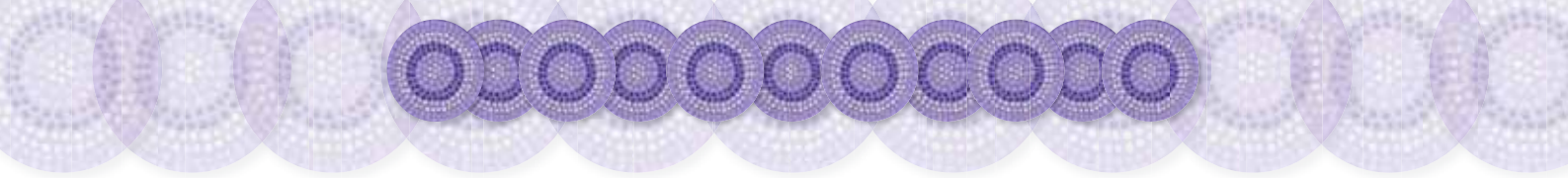
“The girls won’t connect with white counsellors, they won’t do it. They won’t do counselling in here but if there’s a Murri counsellor then maybe they’ll do it.”

Two of these women also felt that a service run by a peer - someone who had been in jail, just like themselves - would be most helpful. As one woman said:

“99% of them haven’t experienced what we’ve experienced and it’s just like a solicitor or a lawyer being an ex-crim ‘cause they know what they’re talking about because they’ve been through it, they’ve experienced it .... and it’s someone who can stand there and say I’ve been down that road and look at me now. So there is a positive in the future.”

In terms of education, several women identified general themes such as opportunities to participate in parenting courses, or cultural education including history and language of Indigenous people.

Mental health education was identified as important and included education about the symptoms of mental health problems and ways to cope with them, the kinds of mental health services that are available in jail and in the community, and simple stress relief techniques. For example:



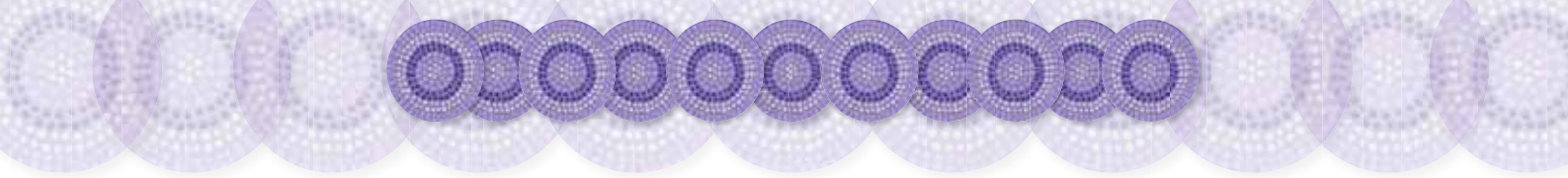
“I think for us Indigenous girls I think education about depression and mentally stuff and stressful stuff like family issues. I think that needs to be in the women’s prison for help for other young girls coming through and even old ones like my aunty is in here and she’s been in and out of Boggo Road for twenty to thirty years easy.”

Several women felt that more counselling should be available; specifically a type of counselling that enabled the opportunity for the women to tell their stories in a group format, supported by other Indigenous women. The women who had received counselling in prison felt that it wasn’t very personal and didn’t feel emotionally supported by it:

“I think the Murri girls need getting together as a whole. What they do here is they segregate you here from everyone else. All the other Murri girls in the centre you know. You can’t mix with them because you’re from RES [residential] and they’re from Secure and you just can’t mix with them. They need to relax on that and realise that it actually helps us as a group to get together. The only time you are allowed to do that is when the Elders come in.”

Other suggestions included regular visits by Elders, more activities to counteract boredom (which one woman suggested was why people took drugs), such as playing football, or learning about culture. An interesting suggestion was to have a service that worked to keep family and community connections alive for incarcerated women. For example, by taking recent photos of the children to bring in to the mothers, as described below:

“So it would be good if you had somebody, especially lots of the girls who come to around Brisbane way say. Like if you had somebody from around the suburbs you could actually go to that family and say I wanna get some photos of such and such’s kids and then would take the picture, print them out for you.”



4. Implications

This study has identified that PTSD is highly prevalent among Indigenous women in custody. In addition the presence of PTSD among Indigenous women in custody is associated with marked mental health disadvantage reflected in a greater likelihood of co-occurring mental illness, higher psychological distress, more suicidal thoughts and actions, a negative sense of self and feelings of a lack of empowerment. We also observed a strong association between PTSD and substance use disorders, particularly cannabis and alcohol disorders. Critically, most of those who suffered PTSD had never accessed health care for the condition and of those who had, most were dissatisfied with the care they had received.

We also identified that the majority of women with PTSD had been suffering the condition for most of their adolescent and adult life. Sexual assault and rape were among the most common trauma experiences for these women, with a high proportion experiencing this trauma before the age of 10. The unexpected and traumatic loss of a loved one was also a significant source of trauma for many, and may reflect the gap in life expectancy between Indigenous and non-Indigenous Australians (37).

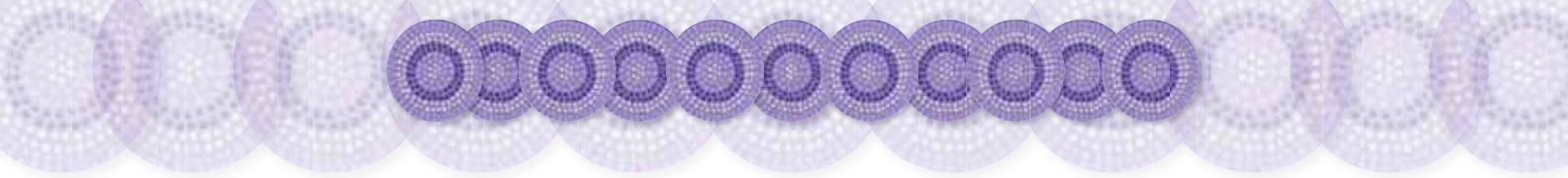
This research has provided for the first time an evidence base to inform the identification of Indigenous women in custody with PTSD. We have highlighted the nature, extent and impacts of symptoms experienced by those suffering PTSD, and highlighted some of the key aetiological factors. We hope that these findings will inform consideration of how best to manage this condition, both in custody and after return to the community.

PTSD in Indigenous women in custody is a serious public health concern. These individuals, who are mostly mothers and potentially leaders in their community, enter and leave custody, sometimes repeatedly, with a major mental disorder that remains untreated. The high rates of death and morbidity during the transition from prison to community (38) cannot be ignored, nor can the dramatic over-representation of Indigenous women in custody.

While the findings of this research might be considered limited by the relatively small sample size and the challenges of adapting methods to minimise cultural bias, significant attempts have been made to overcome these challenges through the use of culturally competent research methodologies and by utilising a sampling period that was almost a year in duration. This is the largest and most comprehensive study ever of PTSD amongst Indigenous women in custody. We believe, based on examining epidemiological studies of female prisoners in Australia (14, 15, 39, 40), that the findings are generalisable across Australia.

Further Research

The data collected in this study will be subjected to further analysis and it is anticipated that a series of peer-reviewed publications will follow this report. Key topics will include a proposed screening instrument for the identification of PTSD among Indigenous women in custody, detailed consideration of the co-occurring mental health and substance use experiences and treatment needs of this group, the role of sexual assault in the aetiology of PTSD and approaches to trauma-informed care, the role of growth and empowerment in preventing and treating PTSD, and barriers to appropriate mental health care for Indigenous women before, during and after periods of incarceration.



5. Recommendations

Based on the findings of the current research, combined with existing literature, in this section we propose general and mental health service specific directions for PTSD intervention for Aboriginal and Torres Strait Islander women in custody.

Recommendation 1: That correctional services and other departments and agencies in contact with this vulnerable population adopt a trauma-informed approach to care.

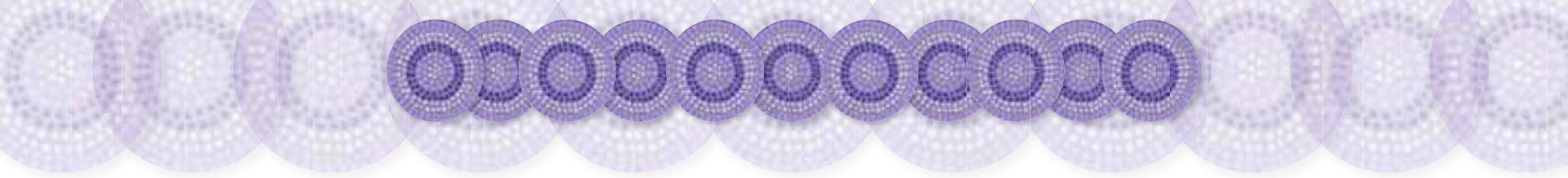
Approaches to trauma-informed care have been well described both internationally (3, 41-43) and within Australia (44). This approach is not specific to mental health service delivery and is not a PTSD-specific treatment intervention. Rather it is a philosophy and approach to service delivery that may be adopted by organisations working with vulnerable populations. Trauma-informed approaches ask “What has happened to you?” rather than “What is wrong with you?”, recognising both the prevalence of trauma and the likelihood that service users will have had such an experience, in addition to the potential link between trauma and the problems and challenges being faced or presented by the individual. It involves significant staff education to promote understanding and skills, and incorporates this knowledge into policies, practices and procedures at every level of the organisation. It aims to minimise the potential for re-traumatisation and maximise safety, trust, collaboration and individual strengths. These concepts are historically at odds with correctional paradigms, but this is changing as evidenced by services internationally and locally looking towards such approaches (45). The very high prevalence of PTSD among Indigenous women in custody, and more generally the high prevalence of traumatic experiences identified in this study, suggest that this type of approach is justified in correctional settings. Given that women in custody come into contact with a number of services, both in and after release from custody, a whole of government approach involving multiagency collaboration and a common, trauma-informed framework are likely to reduce service gaps and improve effectiveness.

Recommendation 2: That assessing for the presence of PTSD is part of routine practice for mental health services working with Aboriginal and Torres Strait Islander women in custody. Such assessment should be based on psychometrically sound and culturally sensitive screening tools.

In examining trauma experiences in the Australian population, Mills (46) identified that epidemiological surveys using less comprehensive lists of trauma exposures are likely to result in lower estimates of the prevalence of traumatic events. Both the nature and the extent of trauma exposure may vary across population and cultural groups; accordingly, assessment of traumatic experiences should accommodate this diversity in order to minimise under-reporting. In the current study, the Trauma Events Scale was supplemented by a number of culturally informed trauma categories (e.g. stolen generation experiences), experience of which was endorsed by a substantial proportion of study participants. As such, it is recommended that traumatic events related to Indigenous experiences be included in routine screening for incarcerated Indigenous people. Subsequent assessment should endeavor to account for the limitations of current formal diagnostic criteria, which do not adequately account for traumatic events experienced by Indigenous people which may be historical and intergenerational in nature (47).

Given the very high prevalence of PTSD among Indigenous women in custody, we recommend that assessment for PTSD be part of standard practice on reception into custody. During the assessment process, cultural factors should be considered including the identification of culturally relevant traumatic experiences, and the identification of associated PTSD symptoms. In this report we have identified some of these experiences, and some of the associated symptoms.

In addition, it is recommended that further research be undertaken to examine the psychometric properties of PTSD screening tools in both custodial and non-custodial populations of Indigenous women. In this



study a well-established screening tool for PTSD performed poorly, both identifying many women who did not have PTSD and failing to identify some who did have PTSD. The findings of this study may provide useful information for the development of a more effective and appropriate screening tool for Indigenous Australians. Such a tool would require further research to confirm its potential utility in both custodial and non-custodial settings. The development of a screening tool specific to Indigenous Australians could potentially enhance the identification of PTSD, thereby enhancing access to appropriate treatment.

Recommendation 3: That mental health treatment services consider the constraints of the custodial environment in determining the appropriate level and nature of service delivery, in treating an incarcerated individual with PTSD.

Establishing safety is considered an essential precursor to commencing trauma specific treatments (2, 44); this concept can include physical safety as well as emotional stabilisation and the ability to regulate affect (emotion). Focusing on safety and emotional regulation skills is particularly important for incarcerated populations. For Indigenous women in custody, the custodial environment may not be considered physically, emotionally or culturally safe to proceed with in-depth trauma specific interventions. In this regard it is important to understand the individual's experience of custody, given that some individuals experience custody as a place of (relative) safety.

It is equally important to consider safety upon release, and to consider whether a particular custodial episode provides an appropriate opportunity for initiating treatment. For many women, time in custody is relatively short and can be characterised by sentencing uncertainties. It would be inappropriate to attempt specific trauma interventions, involving in-depth exploration of traumatic events, in instances when either the individual does not feel safe or when the length of the therapeutic relationship is likely to be short or unknown. In such circumstances, there is the potential to retraumatise, to leave the individual distressed without the means to cope, or for a negative experience of the therapeutic relationship.

For those on remand whose length of stay is yet to be determined, and for those with short sentences, it is recommended that focus be on (a) assessment, identification and engagement, and (b) transition to the community and links to appropriate services. For those whose length of stay allows for some engagement in intervention, a number of preliminary therapeutic programs (outlined in Recommendation 5) should be available, with a focus on addressing the impact of PTSD and building coping skills in general, before addressing the trauma itself. In those instances where moving on to trauma-specific treatment is appropriate, it should be delivered by an experienced, appropriately trained and culturally capable practitioner.

Recommendation 4: That narrative therapies are trialed as a primary treatment approach for PTSD in incarcerated Indigenous women.

Most studies examining the treatment efficacy of different therapeutic approaches for PTSD have not focused on Indigenous Australians, let alone Indigenous women in custody. However, in general terms, narrative treatment approaches (48) have been found to be effective in working with Indigenous Australians (2, 49) and can be used in relatively culturally consistent ways. For example, the concept of yarning (50), one-on-one or in a group situation, aligns with the storytelling function of narrative approaches. The concept of 'narrative' in its broader meaning also recurred throughout the qualitative findings of this study: the importance of understanding the history of Aboriginal and Torres Strait Islander people as a group; linking the story of the community and the individual's place in it; the importance of the individual having an opportunity to tell their stories, to hear those of others, and to understand the role that trauma may have played; in addition to developing hopeful versions of the future. As such, there is good reason to recommend narrative therapies as a primary treatment approach for incarcerated Indigenous women with PTSD. Within this framework it is possible to supplement the narrative core with other evidence-based approaches where appropriate, and to address the specific content areas that the current research suggests are important.

Recommendation 5: That a range of therapeutic programs addressing PTSD and its correlates be made available in custody and the community; these should be delivered in a manner that is flexible and responsive to the individual's needs.

As outlined above, preliminary therapeutic programs may focus on establishing safety, emotion tolerance and skill building to minimise the impact of trauma on re-entry into the community, and should incorporate a narrative style. Such programs could include:

- Psychoeducation: It was a theme of the qualitative interviews that many individuals did not previously have knowledge of PTSD or a framework to understand their experiences. As such, psychoeducation about trauma and its impact is essential both for people in custody and for the communities to which they return.
- Cultural education: Consultation supported cultural education as an important component of understanding both challenges such as intergenerational trauma, and positives such as strength and resilience that can be found in cultural experiences and understanding. Connection to community and sense of identity could also be enhanced through exploration of current community relationships and the individual's place in them. Such a process is also consistent with Aboriginal and Torres Strait Islander relationship building, assisting to build safety and a sense of collaboration.
- Drug and alcohol interventions: This study identified a high rate of drug and alcohol dependence in those with PTSD, a finding that has been replicated in other Indigenous populations (47) and is also evident in the broader Australian community (46). This level of comorbidity suggests that drug and alcohol interventions are an essential treatment component and should be integrated into an individual's treatment.
- Emotional regulation and coping skills: The elevated prevalence of suicidal ideation, depression, anxiety, and drug misuse, and comparatively high psychological distress scores in the group with PTSD, suggests that skills to tolerate and manage negative emotional states are essential. Building these skills early is also consistent with the phases of trauma treatment discussed above.
- Negative cognitions: The Post-Trauma Cognitions Inventory identified that negative cognitions about self and the world, and self-blame, were elevated in women with PTSD. Addressing these common cognitions may serve to reduce the impact of traumatic events and improve coping. Traditional methods such as cognitive behaviour therapy (CBT) may be enhanced via the less direct approach of narrative therapy.
- Domestic violence/ healthy relationships: Given the relatively frequent experience of violent traumatic events, and the experience of multiple traumas, individuals may not have had the opportunity to develop a sense of healthy relationships with appropriate boundaries. Depending on release plans, it may also be beneficial to assist in the development of domestic violence safety plans.

Recommendation 6: That mental health assessment and treatment occur in consultation with, and be informed by, Indigenous health practitioners, and that other staff groups in correctional settings be culturally competent.

It was a clear theme of the qualitative interviews that Aboriginal and Torres Strait Islander people value the involvement of Indigenous people in the delivery of health services. This has implications for engagement with services (and therefore identification of need) and corresponds with the need to minimise cultural bias in assessment and treatment processes. It is recommended that assessment and treatment in custodial settings occur in consultation with, and be informed by, Indigenous health workers, and that other staff groups in custodial settings – including custodial officers – be culturally competent. Cultural competency is a complex concept and involves an investment from organisations and individuals over time to continued development of knowledge, partnerships and practice (51). The strong support for service delivery to involve Indigenous people indicated in this research, and elsewhere in the literature (51), also suggests an investment from government, educational institutions and workplaces to support Indigenous workforce development and broader capacity exchange to upskill non-Indigenous staff working with Indigenous people in custodial settings.

Recommendation 7: That consumers are linked to treatment and support services in preparation for transition to the community, and that these services build on therapeutic processes and skill development commenced in custody.

The period following release from custody is a high risk time in terms of mortality and morbidity, and presents many challenges for individuals. It is important that resources are available in communities, as well as in custody, that can support this transition and allow continued building of skills. Developing and aligning such resources requires cross-sectoral partnerships, particularly given the geographical challenges in Australia. In order to effect a smooth transition from custody to community, these cross-sectoral partnerships must crucially include strong partnerships and information sharing between corrective services and relevant community-based treatment and support services. Furthermore, consistent with the social and emotional well being construct, mental health treatment for Indigenous people should focus not only on the individual, but also consider them in the context of their family and community (47).

Recommendation 8: With appropriate ethical and cultural safeguards, that further research is conducted to rigorously evaluate interventions for PTSD treatment among Indigenous women.

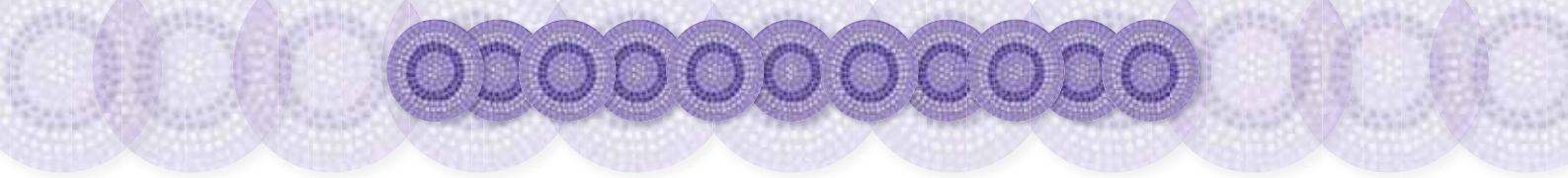
A detailed understanding of the mental health needs of Indigenous women in custody is a prerequisite for the development of informed, evidence-based responses. This study has highlighted the very high prevalence of PTSD among Indigenous women in custody, and for the first time characterised the presentation of this disorder in terms of aetiology, symptoms and comorbidities. Crucially, the study has adopted a culturally informed approach and lays the groundwork for future clinical and policy responses. Ultimately, the value of this research will be measured by the benefits experienced by Indigenous women with PTSD who experience incarceration.

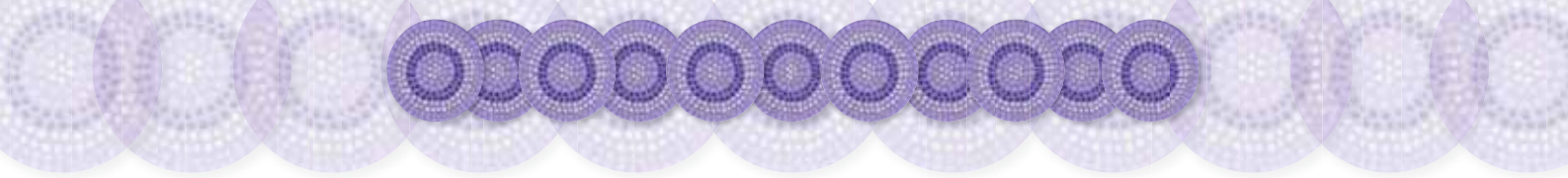
Further research is required to inform development of effective, culturally appropriate responses to PTSD for Indigenous women in custody, and upon their return to communities. Critically, this research must be undertaken in a way that is culturally competent, methodologically rigorous and ethically sound. Translating the findings of this research into action depends on adequate resourcing of services within prisons and in communities, to ensure that mental health services are able to deliver effective and culturally capable mental health care to Indigenous women.

6. References

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7th August 2014 – Forensic Mental Health Queensland

55 people attended the Family Business Forum. Participants were representatives of Aboriginal and Torres Strait Islander communities, Non Government Services associated with Indigenous health or legal issues, Prison Mental Health Services, Corrective Services, Offender Health Services, Community Health Services, Aboriginal and Torres Strait Islander health policy makers, Indigenous health and justice researchers and forensic mental health clinicians.

Welcome to Country by Uncle Sam Watson

Welcome by Aden Ridgeway – Putting a human and cultural context to the issues we deal with. What may the realistic outcomes be? What can we achieve together?

Introduction to the day – Kimina Andersen –Acknowledged the sensitive nature of the topic and the collective historical experience of Aboriginal and Torres Strait Islander people present and need to care for self throughout the day.

Nicky - Personal journey: How trauma history led to substance misuse, incarceration – empowerment – new path - positive change .

Dr Edward Heffernan – Presented on the findings of the quantitative component of the research – The Family Business.

Kimina Andersen – Presented: What the women told us: The Family Business
Qualitative component of research and GEM (Growth and Empowerment Measure) findings

Presenters received questions from the audience, which was followed by group work activities.

Group Discussion

We were asked to consider implications and risk factors for service provisions in a number of domains;

1. For both women in custodial settings and women transitioning to and/from community settings. This was then examined in relation to ;
  - What clinical responses were required AND
  - What social and emotional wellbeing response is required within these settings

Panel Discussion

Key questions:

1. If the barriers were removed what would a system look like to address PTSD for women in custody and in community
2. Should there be a more collective of individual response and approach to preventing and treating PTSD

3. What are the three most important things that come to mind when treatment women in PTSD?
4. Should we start treating PTSD in custody?
5. How do we make sure women's needs are prioritized and we keep this on track?

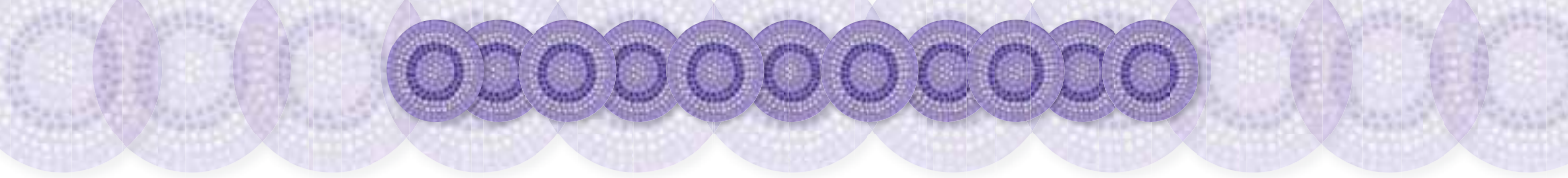
Panel members:

- Dea Delaney-Thiele; Aboriginal Medical Service. Western Sydney
- Edward Heffernan; Qld Forensic MH Service
- Norita Morseu-Diop; Community Controlled Sector/Consultant Brisbane
- Stuart Kinner, University of Melbourne
- Kate Holman; GM Brisbane Women's Correctional Centre
- Katherine Mills; University of Sydney
- Derek Chong; Institute for Urban Indigenous Health Brisbane

Statement / Way Forward

Given the high rates of incarceration of Aboriginal and Torres Strait Islander peoples there needs to be a nationally consistent approach that ensures:

- Culturally appropriate / sensitive initiatives need to be resourced and funding / resources need to match the statistics
- Healing Centers (MC) that integrate between prisons, corrections, health and community NGOs including AMSs to improve the pathways between these systems
- Implementation of a trauma informed model of service provision across all corrective services
- Healing centers that look after the needs of Aboriginal
- Implementation of a model of informed trauma services
- Acknowledging the needs for cultural healing programs in correction and transition
- Program and information sharing needed e.g. what's happening in Canada and NZ - need to adopt similar programs in our corrective programs and systems
- Identify what it is we really want to achieve - identify the goal so we know what sort of services needed and can be accountable
- Build a transition bridge between what services are provided to women inside and outside – continuity of care. Make sure the needs of women met through in-reach
- How women and women respond to cultural activities e.g community members visiting or cultural programs.. There is something good when you see collective families celebrating and practicing culture together – need to enhance this in all programs.
- Employment – “does help the current situation, having positive role models have helped me achieve what I needed to, I wouldn't be here without my role models.”
- Cultural appropriate environment needed for healing, treatment and care so women feel comfortable and will engage with counselors, clinicians.
- Therapeutic prisons – culturally appropriate treatment and support, change purpose / aim of prisons e.g. international examples. Change the system.
- Continuity of care of patient – information sharing between service providers e.g. Corrections and Qld Health
- Educating the community about PTSD - remove stigma and racism
- Asking incarcerated women what they want and what they need help with – let them control and decide their treatment and care.
- Communication key area
- Leadership –responsibilities
- Narrative – yarning circles, no one is higher than anyone else – all equal
- There needs to be some importance and change in narrative and story telling. There needs to be a



shift and effort to change minds and system of letting Aboriginal peoples to decide on what programs are best for them

- Need capacity building to ensure that workforce and organisations are capable of delivering programs and services that are needed
- There is a lot of good will and great ideas, a lot of government departments here. We need someone or a group to move this forward and take responsibly for moving this forward.

Closing Forum:

Kimina and Ed – remarked on the day’s activities and thanked participants. Aden Ridgway made closing remarks and closed the forum.

Appendix 2: Survey Questionnaire

The Family Business

POST TRAUMATIC STRESS DISORDER IN
ABORIGINAL AND TORRES STRAIT ISLANDER
WOMEN IN CUSTODY

QUESTIONNAIRE BOOKLET

(Section 1: consent forms omitted)

Section 2: Participant Details

2.1 This section looks at the Demographic details of the Participants.

		COMMENTS/ NOTES
2.1A Age	..... (In Years)	
2.1B Aboriginal and Torres Strait Islander Status	☐ 1. Aboriginal ☐ 2. Torres Strait Islander ☐ 3. Aboriginal and Torres Strait Islander ☐ 4. Other	
2.1c First Language	☐ 1. Did Not Complete Year 8 ☐ 2. Completed Year 8 ☐ 3. Completed Year 9 ☐ 4. Completed Year 10 ☐ 5. Completed Year 11 ☐ 6. Completed Year 12 ☐ 7. Completed Tertiary Qualification ☐ 8. Completed Technical Or Trade Certificates ☐ 9. Other	
2.1e Do you have any children?	☐ 1. YES ☐ 2. NO	
2.1f Are you the primary caregiver for any children under the age of 18?	☐ 1. YES ☐ 2. NO	If yes go to 2.1.g If no go to 2.1 h
2.1G Who is caring for the child/children who you are primary caregiver for?	☐ 1. Government service (child services) ☐ 2. Kinship (family) ☐ 3. Friend ☐ 4. Other_____	
2.1H Have you ever been diagnosed with a mental health problem by a health professional ?	☐ 1. Alcohol problem ☐ 2. Drug problem ☐ 3. Schizophrenia ☐ 4. Personality disorder ☐ 5. Depression ☐ 6. Anxiety disorder ☐ 7. Post traumatic stress disorder ☐ 8. Drug induced psychosis ☐ 9. Nervous breakdown ☐ 10. Other	

Section 3: Short screening measure for DSM-IV PTSD

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month . . .

3.1. Do you avoid being reminded of <u>the experience</u> by staying away from certain places, people or activities?	☐ 1. Yes ☐ 2. No	
3.2. Have you lost interest in activities that were once important or enjoyable?	☐ 1. Yes ☐ 2. No	
3.3. Have you begun to feel more distant or isolated from other people?	☐ 1. Yes ☐ 2. No	
3.4. Do you find it hard to feel love or affection for other people?	☐ 1. Yes ☐ 2. No	
3.5. Have you begun to feel that there is no point in planning for the future?	☐ 1. Yes ☐ 2. No	
3.6. Have you had more trouble than usual falling or staying asleep?	☐ 1. Yes ☐ 2. No	
3.7. Do you become jumpy or easily startled by ordinary noise or movements?	☐ 1. Yes ☐ 2. No	Total of Yes scores = _____

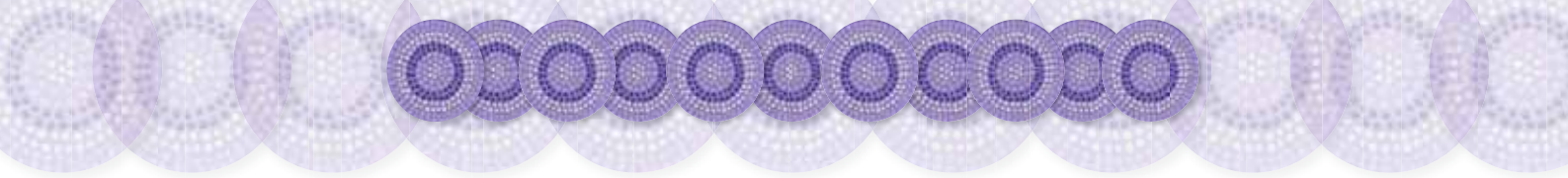
Add the number of yes responses.

If score is 4 or more the Participant is eligible to continue with the study questionnaire.

If the score is <4 thank the Participant for their time and contribution to the Project. Let them know that they do not need to complete any more of the survey. The Participant should be given an opportunity to ask any questions they may have. If you are unable to answer any of the questions the Participants may bring up, please call the Senior Research Investigator. You can also invite the Participant to have a further discussion with the Research Manager if they request.

Section 4: Experience of custody

4.1a Did you ever spend time in youth detention?	☐ 1. Yes ☐ 2. No	If yes move to 4.1B If no move to 4.1C
4.1b How much time did you spend in custody as a youth (<17 years old)	..... months/years	
4.1c How many times have you been in custody as an adult (Including this time)	..... months/years	
4.1d How long have you been in custody this time	..... months/years	
4.1e In total how much time have you spent in custody as an adult (>16 years old)	..... months/years	
4.1f Custody status	☐ 1.Remanded ☐ 2. Sentenced ☐ 3. Remanded & sentenced	
4.1g Correctional centre security status	☐ 1. Mainstream ☐ 2. Protection	
4.1h What is the most serious offence that you have been charged with in relation to your current sentence?	☐ Violent offence (but not sexual offence) ☐ Non violent sexual offence ☐ Drug related offence (drug charges) ☐ Acquisitive offence (property crime, fraud, any offence to get \$ or items to trade e.g. Dealing in stolen goods to get drugs) ☐ Disorder and behavioural offence (DUI, affray, drug and disorderly) ☐ Administrative (breach parole) ☐ Other (please specify): ☐ _____	Interviewer note: if participant provides consent, information for 4.1h and 4.1i will be collected from QCS IOMS database



4.1i

What is the most serious offence that you have ever been charged with?

- ☐ Violent offence (but not sexual offence)
- ☐ Non violent sexual offence
- ☐ Drug related offence (drug charges)
- ☐ Acquisitive offence (property crime, fraud, any offence to get \$ or items to trade e.g. Dealing in stolen goods to get drugs)
- ☐ Disorder and behavioural offence (DUI, affray, drug and disorderly)
- ☐ Administrative (breach parole)
- ☐ Other (please specify): _____

Section 5: Social circumstances

This section looks at the social circumstances of the Participant before coming into custody on this occasion.

I would now like to ask you some questions about your social circumstances.
Please think about the following questions and consider which best describes you
and your circumstances in the TWO MONTHS BEFORE custody.
(The arrest related to this custodial sentence.)

5.1a Relationship status in the two months prior to custody (tick most applicable)	☐1. Single ☐2. Girlfriend/boyfriend ☐3. Married/defacto ☐4. Divorced/separated ☐5. Widowed ☐6. Other	
5.1b Where were you living in the two months before you came into custody on this occasion?	Insert name of town, suburb and/or city _____ Post code (if known) _____	
5.1c Type of accommodation (Tick all applicable for the two months prior to custody)	☐1. Hostel/motel/ boarding house ☐2. Supported accommdation ☐3. Sleeping rough/homeless/no fixed permanent address ☐4. Own home ☐5. Private rental accommodation ☐6. Community housing ☐7. Other	
5.1d Main income source in the two months prior to custody (tick all that apply)	☐1. Centrelink ☐2. Full time work ☐3. Part time work ☐4. From friends and family ☐5. Criminal activity ☐6. Cdep ☐7. Other	

Section 6: Health care

This section looks at the Participants health care in the **Twelve MONTHS** prior to coming into custody.

I would now like to ask you some questions about your health care.
Specifically I would like to ask you about using health care services in the
12 months before you came into custody

6.1a Did you attend health professional/s for any health needs in the 12 months prior to custody? (Tick all that apply)	☐ 1. Gp/local doctor ☐ 2. Local community health centre/clinic ☐ 3. Drug and alcohol services ☐ 4. Traditional healer/medicine ☐ 5. Hospital emergency department ☐ 6. Other ..... ☐ 7. Have never accessed health care	
6.1b Did you attend a professional for mental health needs in the 12 months prior to custody? (Tick all that apply) If the participant responds yes, continue onto 6.1 c & d If no – go to section 7	☐ 1. Psychiatrist ☐ 2. Gp ☐ 3. Community mental health services ☐ 4. Inpatient mental health services ☐ 5. Counsellor ☐ 6. Support group ☐ 7. Traditional healer/medicine ☐ 8. Hospital emergency department ☐ 9. Other ..... ☐ 10. Did not access mental health care	If no – go to section 7
6.1c Were you satisfied with the health care you received? If participant answers 4 or 5 continue to 6.1 d	☐ 1. Totally ☐ 2. Mostly ☐ 3. Neither satisfied nor dissatisfied ☐ 4. Somewhat dissatisfied ☐ 5. Totally dissatisfied	
6.1d WHY were you dissatisfied? (choose the most appropriate response – 1 only)	☐ 1. The clinician or service did not adequately listen to your health concerns ☐ 2. The clinician or service did not properly explain the health care ☐ 3. The clinician or service did not understand how to relate to Indigenous people ☐ 4. The clinician or service discriminated against you because you were an Indigenous person ☐ 5. Other	

Section 7: Post Release Planning

For those who anticipate release from custody in the next 12 months

This section looks at the social circumstances people anticipate they might experience when they are released from custody.

I would now like you to think about yourself in the two months after your release from this centre

7.1a When do you expect to get released	..... Months/years If response is 1 year or more ..... Go to section 8	
7.1b Do you have accommodation available to you when you leave here?	☐ 1. Yes ☐ 2. No ☐ 3. Don't know	If no – go to section 7
7.1c Do you plan to return to where you usually live	☐ 1. Yes ☐ 2. No ☐ 3. Don't know	
7.1d Are you worried about returning there (Tick all that apply)	☐ 1. Yes.....Go to 7.1E ☐ 2. No..... Go to 7.2A ☐ 3. Don't know	
7.1e Can you identify your major concern about returning there?	☐ 1. Payback issues (retaliation) ☐ 2. Police issues (e.G. Targeted by police) ☐ 3. Accommodation (unstable accommodation, accommodation no longer available) ☐ 4. Job issues (no employment opportunities) ☐ 5. Family issues ☐ 6. Other.....	

Section 7: Post Release Planning

This section looks at the Participants health care plans post release

Thinking about what you might do to look after your health in the first two months after you leave this centre

7.2a Do you plan to access <u>mental health</u> services? (Tick all that apply)	☐ 1. No ☐ 2. Psychiatrist ☐ 3. Gp ☐ 4. Community mental health services ☐ 5. Inpatient mental health services ☐ 6. Counsellor ☐ 7. Support group ☐ 8. Cultural healer ☐ 9. Other	
7.2b Do you plan to access <u>any health services</u> ? (Tick all that apply)	☐ 1. No ☐ 2. GP/local doctor ☐ 3. Local community health centre ☐ 4. Local community clinic ☐ 5. Drug and alcohol services ☐ 6. Cultural healer ☐ 7. Other	

Section 8: Suicide

This section looks at the Participants experience of suicide and thoughts of suicide they may have experienced themselves

I am now going to ask you some questions that can be hard to talk about. The questions are about suicide and upsetting things that may have happened in the past. Please tell me if you do not wish to talk about these things or if you feel like a break at any stage after we begin.

Sometimes people feel so down or stressed that they think about suicide;

8.1a Have you ever had someone who is close to you (family or friend) suicide?	☐ 1. Yes ☐ 2. No ☐ 3. No answer	
8.1b Have you ever had thoughts about suicide or ending your own life	☐ 1. Yes ☐ 2. No ☐ 3. No answer	
8.1c Have you had thoughts of suicide in the last 12 months	☐ 1. Yes ☐ 2. No ☐ 3. No answer	
8.1d Have you ever deliberately hurt yourself without wanting to end your life	☐ 1. Yes ☐ 2. No ☐ 3. No answer	
8.1e Have you ever attempted suicide (because you wanted to end your life)	☐ 1. Yes.....Go to q 8.1F ☐ 2. No .....Go to q 8.1G ☐ 3. No answer	
8.1f Have you ever attempted suicide (because you wanted to end your life)	☐ 1. Yes ☐ 2. No ☐ 3. No answer	
8.1g Do you have any current serious thoughts about suicide or ending your life?	☐ 1. Yes ☐ 2. No ☐ 3. No answer	
8.1h Do you want to talk to someone about what we just discussed?	☐ 1. Yes ☐ 2. No ☐ 3. No answer	

Please inform the Senior Research Investigator immediately if:

- the Participant is distressed or upset by these questions, and/or
- the Participant reports yes or does not answer the last two questions (8.1g and 8.1h,).

Asking these questions can also be difficult for you. Debriefing opportunities are available to you.

Section 9: Psychosis Screening

This section is a screening for Psychosis; it asks the Participants to answer questions about their thinking and thoughts.

I am now going to ask you some questions about the way you might think, and what you might think about. Some of these questions might seem unusual; just answer the questions as accurately as possible.

				✓	
9.1	Have you ever felt that your thoughts were being directly interfered with or controlled by		1.Yes		
			5. No		GO TO Q 9.2
			8. Don't know		GO TO Q 9.2
			9. Refused		GO TO Q 9.2
9.1a		Did it come about in a way that many people would find hard to believe, for instance, through telepathy?	1.Yes		
			5. No		GO TO Q 9.2
			8. Don't know		GO TO Q 9.2
			9. Refused		GO TO Q 9.2
9.1b		Has this occurred in the past 12 months?	1.Yes		
			5. No		
			8. Don't know		
			9. Refused		

				✓	
9.2	Have you ever had a feeling that people were too interested in you?		1.Yes		
			5. No		GO TO Q 9.3
			8. Don't know		GO TO Q 9.3
			9. Refused		GO TO Q 9.3
9.2a		Have you ever had a feeling that things were arranged so as to have a special meaning for you, or even that harm might come to you?	1.Yes		
			5. No		GO TO Q 9.3
			8. Don't know		GO TO Q 9.3
			9. Refused		GO TO Q 9.3
9.2b		Have you had these feelings in the past 12 months?	1.Yes		
			5. No		
			8. Don't know		
			9. Refused		

				✓	
9.3.	Have you ever had any special powers that most people lack?		1.Yes		
			5. No		GO TO Q 9.4
			8. Don't know		GO TO Q 9.4
			9. Refused		GO TO Q 9.4
9.3a		Do you belong to a group of people who also have these powers?	1.Yes		GO TO Q 9.4
			5. No		
			8. Don't know		GO TO Q 9.2
			9. Refused		GO TO Q 9.2
9.3b		Have you had these special powers in the past 12 months?	1.Yes		
			5. No		
			8. Don't know		
			9. Refused		

				✓	
9.4	Has a doctor ever told you that you may have schizophrenia?		1.Yes		
			5. No		
			8. Don't know		
			9. Refused		

	✓ Answer Yes	
9.1b		Positive screen → see research manager
9.2b		Positive screen → see research manager
9.3b		Positive screen → see research manager
9.4b		Positive screen → see research manager

Section 10: Past trauma events

I am going to ask you some questions about events in your past which might have been traumatic. Can you tell me if any of these things have happened in your past?

Please tick ✓

		Yes	No	Don't Know	Refused
10a.	Do you identify as a member of the stolen generations?				
10b	Did either of your parents ever identify as being a member of the stolen generations?				
10c	Have you ever been removed from your family environment as a child?				
10d	Did you ever experience a sibling being removed from your family environment?				
10e	Have you had children who were taken away from you by the government?				
10f	Have you been subjected to racism and discrimination?				
10g	Have you ever felt that you were not accepted by your own family?				
10h	Have you ever felt that you were not accepted by your own community?				

Section 11: CIDI

Information collection via WHO-CIDI CAPI

Section 12: Your feelings in the last month

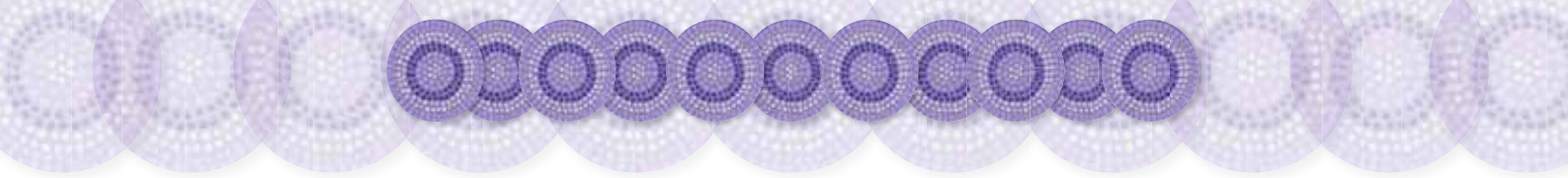
In the last one month,		None of the time	A little of the time	Some of the time	Most of the time	All of the time
0	How often did you feel happy in yourself?	0	0	0	0	0
1	How often did you feel so sad that nothing could cheer you up?	0	0	0	0	0
2	How often did you feel nervous?	0	0	0	0	0
3	How often did you feel restless or fidgety?	0	0	0	0	0
4	How often did you feel without hope?	0	0	0	0	0
5	How often did you feel everything was an effort?	0	0	0	0	0
6	How often did you feel worthless?	0	0	0	0	0
7	How often did you feel angry with yourself or others?	0	0	0	0	0

Section 13: Trauma Symptom Checklist

(Briere & Runtz, 1989)

How often have you experienced each of the following in the last month? Please tick one number, 0-3.

	SYMPTOM	NEVER....OFTEN			
		0	1	2	3
13.1	Insomnia				
13.2	Weight loss (without dieting)				
13.3	Stomach problems				
13.4	Feeling isolated from others				
13.5	'Flashbacks' (sudden, vivid, distracting memories				
13.6	Restless sleep				
13.7	Low sex drive				
13.8	Sexual problems				
13.9	Sexual overactivity				
13.10	Not feeling satisfied with your sex life				
13.11	Having sex that you didn't enjoy				
13.12	Bad thoughts or feelings during sex				
13.13	Being confused about your sexual feelings				
13.14	Sexual feelings when you shouldn't have them				
13.15	Anxiety attacks				
13.16	Loneliness				
13.17	Nightmares				
13.18	'Spacing out' (going away in your mind)				
13.19	Sadness				
13.20	Dizziness				
13.21	Trouble controlling your temper				
13.22	Waking up early in the morning				
13.23	Uncontrollable crying				
13.24	Fear of men				
13.25	Not feeling rested in the morning				
13.26	Trouble getting along with others				
13.27	Memory problems				
13.28	Desire to physically hurt yourself				



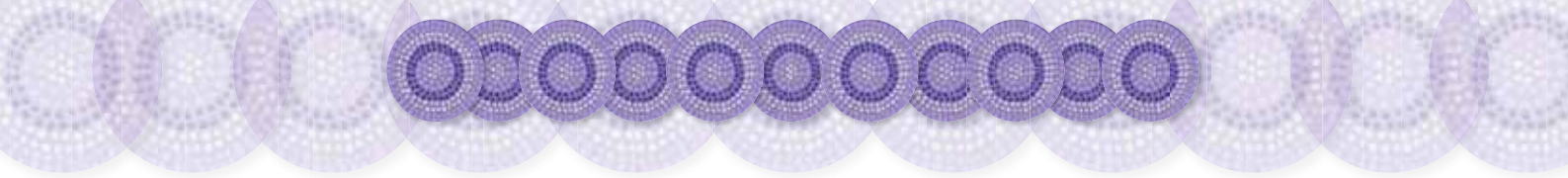
SYMPTOM		NEVER....OFTEN			
		0	1	2	3
13.29	Fear of women				
13.30	Waking up in the middle of the night				
13.31	Passing out				
13.32	Feelings that things are ‘unreal’				
13.33	Unnecessary or over-frequent washing				
13.34	Feelings of inferiority				
13.35	Feeling tense all the time				
13.36	Desire to physically hurt others				
13.37	Feelings of guilt				
13.38	Feeling that you are not always in your body				
13.39	Having trouble breathing				
13.40	Headaches				

Section 14: Posttraumatic cognitions inventory

We want to ask you some question about your thoughts.
Rate how much you agree with these statements from 1 to 7.

1	2	3	4	5	6	7
<i>totally disagree</i>	<i>disagree very much</i>	<i>disagree slightly</i>	<i>neutral</i>	<i>agree slightly</i>	<i>agree very much</i>	<i>totally agree</i>

14.1	The event happened because of the way I acted	
14.2	I can't trust that I will do the right thing	
14.3	I am a weak person	
14.4	I will not be able to control my anger and will do something terrible	
14.5	I can't deal with even the slightest upset	
14.6	I used to be a happy person but now I am always miserable	
14.7	People can't be trusted	
14.8	I have to be on guard all the time	
14.9	I feel dead inside	
14.10	You can never know who will harm you	
14.11	I have to be especially careful because you never know what can happen next	
14.12	I am inadequate	
14.13	If I think about the event, I will not be able to handle it	
14.14	The event happened to me because of the sort of person I am	
14.15	My reactions since the event mean I am going crazy	
14.16	I will never be able to feel normal emotions again	
14.17	The world is a dangerous place	
14.18	Somebody else would have stopped the event from happening	
14.19	I have permanently changed for the worse	
14.20	I feel like an object, not like a person	
14.21	Somebody else would not have gotten in this situation	
14.22	I can't rely on other people	
14.23	I feel isolated and set apart from others	
14.24	I have no future	
14.25	I can't stop bad things from happening to me	
14.26	People are not what they seem	
14.27	My life has been destroyed by the trauma	



14.28	There is something wrong with me as a person	
14.29	My reactions since the event show that I am a lousy copier	
14.30	There is something about me that made the event happen	
14.31	I feel like I don't know myself anymore	
14.32	I can't rely on myself	
14.33	Nothing good can happen to me anymore	

Section 15: Growth and Empowerment

Now I'd like to switch to a different type of question. I'd like to ask you which of the circumstances that I will describe, sound the most like you.

Show the participant the laminated picture cards (GEM).

Interviewer: Ask the main question of each page – explain that there are four different phases to select from.

Participants can also decide that the situation that they identify with is in between two of the phases.

Read the responses from left to right. If a participant indicates that they identify with one of the phases, read the next phase to them and ask them if this one represents them better.

1. How do you deal with painful feelings and the bad things that have happened in your life?

Please tick **ONLY ONE** box below that best describes the way you see your situation.



So much pain, anger and bad feelings are **bottled up** inside me.

I **haven't begun** to address this.

It **stops me** from moving ahead.

Are you
partly this
&
partly that?
If so, please tick
this box

Are you here? If so, please tick this Box ☐



I am **beginning to open up and talk about** myself.

I have **started to deal with the** feelings that are bottled up inside me.

Its painful, but I **can see the** benefits.

Are you
partly this
&
partly that?
if so, please tick
box

Are you here? If so, please tick Box ☐



I have been able **to work through some** of my feelings and emotions.

I am **beginning to move ahead** in my life.

I **still have some ways to go to deal** with what has happened to me and my community.

Are you
partly this
&
partly that?
If so, please
tick box

Are you here? If so, please tick Box ☐



I can say that I have **worked through or moved on** from much of the bad experiences and struggles I've had.

These **no longer hold me back** from moving ahead with others into a better future.

Are you here? If so, please tick Box ☐

2. How do you deal with safety for yourself?

Please tick **ONLY ONE** box below that best describes the way you see your situation.



I just put up with things that harm me. I often get hurt physically, or emotionally. I haven't found a way to escape or stop this. I feel too shame to get help.

Are you partly this & partly that? If so, please tick box

☐

Are you here? If so, please tick Box

☐


When things get frightening, I escape in order to protect myself and my family. I find it hard to trust anyone. But I am starting to be able to ask for help for physical safety if I need it.

Are you partly this & partly that? If so, please tick box

☐

Are you here? If so, please tick Box

☐


I am learning to take positive steps to protect myself and family against physical and emotional harm. I am starting to trust people to help me stay safe emotionally as well as physically.

Are you partly this & partly that? If so, please tick box

☐

Are you here? If so, please tick Box

☐


I have a strong ability to protect myself and my family from things that could harm me. I feel emotionally and physically secure. I don't have to run away. I am able to trust other people when appropriate.

Are you here? If so, please tick Box

☐

3. How do you feel about making changes in your life?

Please tick **ONLY ONE** box below that best describes the way you see your situation.



There are things that I should change in my life to be healthier and happier.

But it seems all too hard.

I don't think I can change anything at this time.

Are you partly this & partly that? If so, please tick box

Are you here? If so, please tick Box ☐



I have **started to think** about some changes I'd like to make that would be good for me.

But I **don't have skills or confidence** to make the changes.

I try but I usually fall back to my old ways.

Are you partly this & partly that? If so, please tick box

Are you here? If so, please tick Box ☐



I have **thought a lot** about changes I'd like to make that will be good for me.

I have **gained some skills & confidence** to make changes.

I have had some **successes**, but I **still don't feel fully confident** about making change.

Are you partly this & partly that? If so, please tick box

Are you here? If so, please tick Box ☐



I have **gained skills and confidence and have succeeded** in making many important changes in my life.

I feel fully confident about my ability to make changes.

Are you here? If so, please tick Box ☐

4. Do you have a strong sense of knowing who you are?

Please tick **ONLY ONE** box below that best describes the way you see your situation.



I don't know
who I am.
I don't know
where I am
going in my life.
Without this,
I feel lost.

Are you
partly this
&
partly that?
If so, please tick
box

Are you
here? If so,
please tick
Box ☐



**I have a pretty
good idea** of who
I am, but people
put labels on me
and these affect
me.

**I am struggling
with being
myself and
pretending** to be
what others
expect of me.

Are you
partly this
&
partly that?
If so, please tick
box

Are you
here? If so,
please tick
Box ☐



**I am lifting off
the labels** that
other people
have given me
and other things
about me that
are not really
who I am.

**I've stopped
pretending.**
But I still have a
long way to go to
truly know and
be myself.

Are you
partly this
&
partly that?
If so, please
tick box

Are you
here? If so,
please tick
Box ☐



**I'm very strong
about who I am.**

**I am proud of my
cultural identity.**

**I now fully
understand** what
that means to me.

Are you here?
If so, please
tick Box ☐

5. Are you able to speak out and be heard in your community?

Please tick **ONLY ONE** box below that best describes the way you see your situation.



I am too shy or shame to speak out in this community.

I have little or no say in what happens here.

I have no voice.

Are you
← partly this
& →
partly that?
If so, please tick
box

☐

Are you
here? If so,
please tick
Box ☐



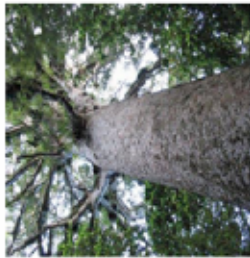
I am beginning to speak out and have some say on some issues.

I have a long way to go to make sure my voice is heard and respected.

Are you
← partly this
& →
partly that?
If so, please tick
box

☐

Are you
here? If so,
please tick
Box ☐



I am able to speak out and be heard.

My views are considered when decisions are made this community.

But I could be more involved in how things are decided and done here.

Are you
← partly this
& →
partly that?
If so, please
tick box

☐

Are you
here? If so,
please tick
Box ☐



I am fully part of the decision-making process in this community as an individual or a member of an active group. People respect what I say even when we disagree.

Are you here?
If so, please
tick Box ☐

6. How do you see your relationships with other people?

Please tick **ONLY ONE** box below that best describes the way you see your situation.



I feel completely trapped in my relationships.

I am dealing with things like:
kids out of control, anger and fighting, gossiping, bullying.

Most of my relationships are harmful, not healthy.

Are you partly this & partly that?
If so, please tick box



Are you here? If so, please tick Box



I am gaining an understanding of my difficult relationships.

I have started to think about how to make them better. I think more about what I'm saying.

I still have a lot of work to do to improve my relationships.

Are you partly this & partly that?
If so, please tick box



Are you here? If so, please tick Box



I have made a lot of progress in improving my relationships.

I think a lot about listening and talking sensitively to people.

I see improvement in the way people respond to me.

Are you partly this & partly that?
If so, please tick box



Are you here? If so, please tick Box



My life is now rich and happier because of many good relationships.

My relationships give me peace and harmony in my heart.

I am able to preserve this peace in my home and family, even when we disagree.

Are you partly this & partly that?
If so, please tick box

Are you here? If so, please tick Box

Appendix 3: Charges

	PTSD (n=60) n (%)	Non PTSD (n=56) n (%)	Completed Full Study(N=116) n (%)
Most serious offence (type) - current incarceration			
Violence & Acts Endangering Persons	33.3	48.2	40.5
Acquisitive Offences	38.3	32.1	35.3
Drugs	3.3	3.6	3.5
Public Order	3.3	1.8	2.6
Property Damage	3.3	0	1.7
Breach	1.7	0	0.9
Unrecorded	16.7	14.3	15.5
Most serious offence (type) - lifetime			
Violence & Acts Endangering Persons	60.0	57.1	58.6
Acquisitive Offences	25.0	25.0	25.0
Drugs	1.7	3.6	2.6
Public Order	0	1.8	0.9
Property Damage	1.7	1.8	1.7
Breach	1.7	1.8	1.7
Unrecorded	10	8.9	9.5

Appendix 4: CIDI Trauma Events

	PTSD (n=60) n (%)	Non PTSD (n=56) n (%)	OR (95% CI)
Lifetime Trauma Events - CIDI			
Kidnapped or held captive	7 (11.7)	1 (1.8)	7.1 (0.86 – 326.99) p = .04
Involved in life threatening motor vehicle accident	11 (18.3)	5 (8.9)	2.2 (0.67 – 8.98) p = .11
Involved in another life threatening accident	7 (11.7)	2 (3.6)	3.57 (0.63 – 36.35) p = .99
Involved in a major natural disaster	18 (30.0)	6 (10.7)	3.57 (1.21 – 11.9) p = .009
Involved in a man made disaster	6 (33.3)	0 (0)	
Experienced a life threatening illness or injury	4 (6.7)	3 (5.4)	1.26 (0.20 – 9.00) p = .549
As a child, badly beaten up by parent or carer.	20 (33.3)	6 (10.7)	4.17 (1.42 – 13.75) p = 0.003
Badly beaten up by a spouse or romantic partner	31 (51.7)	18 (32.1)	2.26 (0.99 – 5.16) p = .025
Badly beaten up by someone else	10 (16.7)	2 (3.6)	5.4 (1.06 - 52.39) p = .019
Mugged, held up or threatened with a weapon	15 (25.0)	1 (1.8)	18.3 (2.58 – 785.34) p = .0002
Sexual assault – rape	28 (46.7)	7 (12.5)	6.13 (2.36 – 18.37) p = .0000
Sexual assault – other	28 (46.7)	7 (12.5)	6.13 (2.36 – 18.37) p = .0000
Stalked	14 (23.3)	4 (7.1)	3.96 (1.12 – 17.49) p = .014
Someone close died unexpectedly	43 (71.7)	21 (37.5)	4.22 (1.81 – 9.93) p = .0002
Son or daughter had a life threatening illness or injury	8 (13.3)	3 (5.4)	2.72 (0.60 – 16.64) p = .125
Someone close to you had an extremely traumatic experience (kidnap, torture, rape etc).	10 (16.7)	0 (0)	
As a child, experienced serious physical fights at home	27 (45.0)	10 (17.9)	3.76 (1.50 – 9.86) p = .0015
Saw someone being badly injured or killed or unexpectedly saw a dead body	16 (26.7)	7 (12.5)	2.55 (0.88 – 7.97) p = .05

	PTSD (n=60) n (%)	Non PTSD (n=56) n (%)	OR (95% CI)
Did something that accidentally led to serious injury or death of another person	5 (8.3)	1 (1.8)	5 (0.52 – 240.67) p = .12
Purposely seriously injured, tortured or killed another person	3 (5.0)	4 (7.1)	0.67 (0.09 – 4.19) p = .45
Experienced other extremely traumatic event not asked about	2 (3.3)	1 (1.8)	1.90 (0.10 – 113.88) p = .53
Experienced another extremely traumatic event that you don't want to talk about	3 (5.0)	0 (0)	
Number of Trauma Event Types			
Range	1-16	0-9	
Mean	5.3	1.9	

Appendix 5: Additional Questions Trauma Events

Trauma Events – additional questions	PTSD n = 60 n (%)	Non PTSD (n=56) n (%)	OR (95% CI)
Identify as member of the stolen generations	17 (28.3)	10 (17.9)	1.81 (0.69 – 4.95) p = .13
Parents identified as member/s of stolen generations	34 (56.7)	25 (44.6)	1.62 (0.73 – 3.61) p = .13
Removed from family environment as a child	30 (50.0)	29 (51.8)	0.93 (0.42 – 2.06) p = .50
Experienced a sibling being removed from family environment	36 (60.0)	26 (46.4)	1.73 (0.78 – 3.86) p = 0.1
Had children taken by the Government	26 (43.3)	27 (48.2)	0.82 (0.37 – 1.82) p = .37
Subjected to racism or discrimination	46 (76.7)	40 (71.4)	1.31 (0.53 – 3.30) p = .33
Felt not accepted by own family	48 (80.0)	31 (55.4)	3.23 (1.32 – 8.08) p = .003
Felt not accepted by own community	37 (61.7)	25 (44.6)	1.99 (0.89 – 4.47) p = .049

Appendix 6: Sexual Assault

Sexual Assault	PTSD n = 60 n (%)	Non PTSD (n=56) n (%)	
Age at first sexual assault (other than rape)			
0-10 years	17 (18.3)	3 (5.3)	
11-18 yrs	8 (13.3)	3 (5.4)	
>18 yrs	2 (3.3)	2 (3.6)	
Any Age	27 (45.0)	8 (14.3)	OR 4.90 (1.86-13.93) P<.0003
Age at first sexual assault (other than rape)			
range (yrs)	2-30	6-22	
mean (yrs)	9.3	12.4	
Age at first sexual assault (rape) –			
0-10 years	17 (28.4)	3 (5.4)	
11-18 yrs	7 (16.6)	3 (5.4)	
>18 yrs	2 (3.3)	2 (3.6)	
Any Age	26 (43.3)	8 (14.3)	OR 4.59 (1.73-13.03) P<.0006
Age at first sexual assault (rape)			
range (yrs)	2-32	3-29	
mean (yrs)	10.2	13.4	

Appendix 7: Trauma Symptom Checklist Subscales

Trauma Symptom Checklist	PTSD n = 60 mean	Non PTSD (n=56) mean	P
Dissociation	7.2	4.0	.000
Anxiety	13.0	8.4	.000
Depression	12.2	7.6	.000
Sexual Abuse Trauma Inventory	8.6	4.5	.000
Sleep Disturbance	7.7	4.9	.000
Sexual Problems	10.0	6.1	.000
Total	54.3	33.8	.000

Appendix 8: Post Traumatic Cognitions Inventory Subscales

Posttraumatic Cognitions Inventory (PCTI)	PTSD n = 60 mean	Non PTSD (n=56) mean	P
Negative cognitions about self	3.1	2.3	.002
Negative cognitions about the world	5.1	4.4	.014
Self blame	3.5	2.9	.011
Total Score	117.14	93.4	.001

Appendix 9: Growth and Empowerment Measure (GEM)

Growth and Empowerment Measure Mean Score (Individual scores range from 1-7 with 7 indicating higher level of empowerment)	PTSD n = 59	Non PTSD n=55
How do you deal with painful feelings and the bad things that have happened in your life?	3.2	4.6
How do you deal with safety for yourself?	3.7	5.1
How do you feel about making changes in your life?	4.2	4.9
Do you have a strong sense of knowing who you are?	4.8	5.9
Are you able to speak out and be heard in your community?	4.1	4.4
How do you see your relationships with other people?	4.3	4.9
Mean Score GEM 6 (includes 6 items as listed above)	24.6	31.4

Appendix 10: Health Care Utilisation

Health Care Utilisation Pre Custody 12 month period	PTSD n = 60	Non PTSD n=56	Total (n=116)
Mental Health Services			
Psychiatrist	15 (25.0)	7 (12.5)	22 (18.9)
GP	10 (16.7)	7 (12.5)	17 (14.7)
Community MH clinic	9 (15.0)	4 (7.14)	13 (11.2)
Inpatient MH	6 (10.0)	1 (1.8)	7 (6.0)
Counsellor	12 (20.0)	7 (12.5)	19 (16.4)
Support Group	6 (10.0)	1 (1.8)	7 (6.0)
Traditional healer	0 (0)	0 (0)	0 (0)
Hospital Emergency Dept	3 (5.0)	3 (5.4)	6 (5.2)
Other	2 (3.3)	5 (8.9)	7 (6.0)
No MH Care	26 (43.3)	32 (57.1)	58 (50.0)
Satisfaction with Care			
Satisfied	21 (35.0)	14 (25.0)	35 (30.17)
Neutral	5 (8.3)	3 (5.4)	8 (6.9)
Dissatisfied	7 (11.7)	4 (7.1)	11 (9.5)
No Response	27 (45.0)	35 (62.5)	62 (53.5)

Appendix 11: Post Custody Plan

Post Custody Plan	PTSD n = 60	Non PTSD n=56	Total (n=116)
Mental Health Services			
Psychiatrist	13 (21.7)	11 (19.6)	24 (20.7)
GP	18 (30.0)	15 (26.8)	33 (28.5)
Community MH clinic	13 (21.7)	4 (7.1)	17 (14.7)
Inpatient MH	3 (5.0)	1 (1.8)	4 (3.5)
Counsellor	15 (25.0)	10 (17.9)	25 (21.6)
Support Group	6 (10.0)	4 (7.1)	10 (8.6)
Traditional healer	1 (1.7)	1 (1.8)	2 (1.7)
Other	2 (3.3)	2 (3.6)	4 (3.5)
No MH Care	16 (26.7)	26 (46.4)	42 (36.2)
Accommodation available	48 (80.0)	36 (64.3)	84 (72.4)
Plan to return to where you usually live	34 (56.7)	30 (53.6)	64 (55.2)

